U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

1972 AMENDMENTS
CHART BOOKLET

MEDICARE

SOCIAL SECURITY ADMINISTRATION
FEBRUARY 1973

SS PUB 9-73 (2-73)

This training document is designed for the use of Social Security Administration employees. Information contained in this chart booklet does not alter or supersede regulations, operating procedures, or manual instructions.
The Table of Contents includes the H.R. 1 section numbers so that each chart and narrative can be cross-referred to the statutory provision itself.

OFFICE OF ADMINISTRATION
Division of Training and Career Development

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ELIGIBILITY

Effective: The later of 7/73 or 25th consecutive month of entitlement to disability benefits

MEDICARE FOR THE DISABLED

- PROTECTION EXTENDED TO PERSONS ENTITLED TO CASH DISABILITY BENEFITS FOR AT LEAST 24 CONSECUTIVE MONTHS
- PROTECTION NEEDED BECAUSE THE DISABLED:
  - Have high health care costs
  - Have limited income
  - Have inadequate private health insurance

Medicare for the Disabled

The amendments extend Medicare protection to people who are receiving social security or railroad retirement monthly benefits based on their disability, and who have been entitled to monthly disability benefits for at least 24 consecutive months. The groups of beneficiaries are disabled workers; people 18 and over receiving benefits based on a disability that began before age 22; disabled widows and disabled dependent widowers age 50-64 (widows and widowers will be able to retain their Medicare protection until age 65 even though they later may become entitled to reduced retirement insurance benefits); disabled qualified railroad retirement annuitants; and women age 50 or older entitled to mother's benefits who, for 24 months prior to the first month they would have been entitled to Medicare, met all the requirements for disability benefits except for filing a claim for such benefits.

Under this provision, such beneficiaries are eligible for both hospital insurance and supplementary medical insurance. The Medicare benefits provided disabled beneficiaries—the days of inpatient care, physicians' services, and the like—are identical to those provided the aged.

The Congress extended Medicare protection to these groups because, in general, disabled beneficiaries have medical needs in excess of the aged for whom Medicare was originally designed, and far in excess of the rest of the population. At the same time, they are likely to encounter difficulties in obtaining health care protection for themselves, since in comparison with those who are not disabled, they have limited incomes and are financially unable to buy adequate private health insurance. For example, studies indicate that DI beneficiaries use about seven times as much hospital care and three times as many physicians' services as does the nondisabled population. A DI beneficiary is no longer working and therefore is generally unable to obtain health insurance coverage under a group plan. In most cases, he must rely on individually-purchased policies or group conversion policies for health insurance protection. In general, coverage made available to the disabled on an individual basis—whether or not through conversion—is more expensive than group coverage and more expensive than individual coverage for nondisabled people. Such coverage is likely to be too great an expense for the disabled or the benefits so limited that the coverage cannot be considered adequate.

Requiring that a person must have been entitled to disability benefits for at least 2 consecutive years to be eligible for Medicare protection reflects the concern of the Congress about providing the protection while holding program costs within reasonable bounds, and avoiding possible overlapping of Medicare and private health insurance protection (particularly where a disabled person can continue his membership in a group insurance plan for a period of time following the onset of his disability). The 2-year period, while providing some assurance that Medicare protection is available to those whose disabilities have proven to be severe and long lasting, also helps to reduce administrative problems that otherwise would arise in cases where—because of delayed appeals processing—the final decision regarding entitlement to disability benefits may not be reached until some time after application.

Hospital insurance protection begins with the later of (a) July 1973, or (b) the 25th consecutive month of an individual's entitlement to monthly social security disability benefits. Hospital insurance protection ends with the month after the month that notice of termination of monthly disability benefits is mailed (except the month of death is covered for HI purposes when monthly benefits terminate for that reason).

Supplementary medical insurance protection will begin the same month as hospital insurance unless the beneficiary declines SMI coverage. (See chart 33 regarding automatic enrollment.) The enrollment periods for SMI for the disabled are similar to those already established in the law—the same basic enrollment rules that apply to the aged may be used if the 25th month mentioned above is substituted for the month of attainment of age 65. SMI protection ends with the same month that HI protection ends. The amount of the monthly SMI premiums paid by disability beneficiaries is the same as that paid by the aged. Premiums will be deducted from monthly

disability benefits. As with aged people who do not enroll during their initial enrollment period, the premium amount for the disabled will be somewhat higher for late enrollees.

Q. *Does the 2-year period include the 5-month waiting period in the disability insurance program?*

A. No. A person to whom the waiting period applies is not "entitled" to disability benefits until he has satisfied the waiting period requirement. Therefore, a person who first becomes disabled in the future (and is otherwise entitled) will become entitled to Medicare beginning with the 30th month after the 1st full calendar month of disablement.

Q. *Will Medicare protection be extended to those blind individuals who are entitled to a disability freeze but not to monthly benefits because they are engaging in substantial gainful activity?*

A. No. An individual must be entitled to monthly cash disability insurance benefits.

Q. *What procedure will be used in the case of persons presently receiving benefits who are widows and widowers over age 60 and women receiving mothers' benefits, who may be eligible for disability benefits as well?*

A. Disability determinations will be made as soon as possible in order to determine whether they meet the entitlement requirements for Medicare protection. There is a special provision related to retroactivity of claims filed by disabled widows who are receiving mothers' benefits. Prior to July 1, 1974, any such widow who establishes disability may be deemed entitled to disabled widow's benefits as if she had filed a timely application therefor. For example, mothers who meet the disability requirements on or before July 1, 1971, and file applications before July 1, 1974, will be entitled to Medicare effective July 1973. Widows and widowers who meet disability requirements—and mothers filing after July 30, 1974—will be allowed only the usual 12-month retroactivity applicable to disability claims.

ELIGIBILITY

Effective: July 1973

MEDICARE FOR PERSONS WITH CHRONIC KIDNEY DISEASE

• ELIGIBILITY REQUIREMENTS:

UNDER AGE 65

AND

REQUIRES KIDNEY TRANSPLANTATION OR HEMODIALYSIS

AND

A. CURRENTLY OR FULLY INSURED	OR	B. ENTITLED TO MONTHLY SOCIAL SECURITY BENEFITS	OR	C. SPOUSE OR DEPENDENT CHILD OF PERSON DESCRIBED IN A OR B

• PERIOD OF ELIGIBILITY:

JANUARY	FEB.	MAR.	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER THROUGH NEXT AUGUST	SEPTEMBER
COURSE OF DIALYSIS BEGINS			MEDICARE COVERAGE BEGINS				DIALYSIS ENDS OR TRANSPLANT		FIRST MONTH WITH NO MEDICARE

Medicare for Persons With Chronic Kidney Disease

The 1972 amendments extend Medicare coverage to individuals under age 65 who require hemodialysis or renal transplantation for chronic renal disease and who are currently or fully insured, or entitled to monthly social security benefits, or are the spouses or dependent children of such insured or entitled individuals.

Although many people with chronic kidney disease who otherwise would be considered disabled under social security and thereby eligible under Medicare are able to work because they are receiving hemodialysis, the costs of this continuing treatment are catastrophically high for most families.

Eligibility for Medicare coverage will begin with the 3rd month after the month in which a course of renal hemodialysis begins, but only with respect to services provided on or after July 1, 1973. Medicare coverage under this provision *ends* with the 12th month after the month in which the individual has a kidney transplant or dialysis terminates.

The Medicare coverage extended to individuals under this provision is identical to the coverage of other entitled people. The Secretary of Health, Education, and Welfare is authorized, however, to limit reimbursement for hemodialysis and renal transplantation to those kidney disease treatment centers which meet regulatory requirements, provided those requirements include a minimal utilization rate for covered procedures and a medical review board to screen patients for the appropriateness of the proposed treatment procedures. The purpose of the requirements is to assure that Medicare payments are made only for quality, medically necessary care.

ELIGIBILITY

Effective: July 1973

VOLUNTARY HOSPITAL INSURANCE FOR UNINSURED

- ENROLLEES PAY FULL COST -- $33 PER MONTH
- THOSE ELIGIBLE TO ENROLL
  - AGE 65 AND OVER
  - NOT OTHERWISE ELIGIBLE FOR HI
  - MEET CITIZENSHIP AND RESIDENCY TEST
  - ALSO ENROLLING IN SMI
- STATES AND PUBLIC ORGANIZATIONS MAY PAY ON GROUP BASIS
- INITIAL GENERAL ENROLLMENT PERIOD: DECEMBER 1, 1972 - AUGUST 31, 1973

Voluntary Hospital Insurance for Uninsured

Under this amendment, people 65 and over who meet a residency and citizenship test and who are otherwise ineligible for the hospital insurance part of Medicare may enroll on a voluntary basis. They may enroll if they meet the same requirements that apply to enrollment under the supplementary medical insurance part of Medicare. Enrollees will pay the full cost of the protection—$33 per month. This premium will rise as hospital costs rise. Thus, there are now three major ways people 65 and over become eligible for hospital insurance under Medicare: (1) as a fully insured person or entitled dependent of a fully insured person, (2) as a transitional insured person, or (3) as an uninsured enrollee. People enrolling in HI under this provision must also enroll in SMI.

The substantial majority of the aged are eligible for hospital insurance because they meet (1) or (2) above. However, a small proportion of the aged (2 percent—about 408,000 people) do not meet those requirements and have been excluded from coverage. Further, it is very difficult for many in this group to obtain adequate private hospital insurance protection. Since 1965, private insurance companies generally have changed the hospital insurance plans they make available to the aged to make their coverage complementary to Medicare. While there is generally some type of hospital insurance available to the age 65 and over group, most of the policies offered now provide for cash payments (ranging from $25 to $200 per week) for limited periods of hospitalization. Few private health insurance companies offer their regular plans to the aged.

The new law provides for a 9-month *initial general enrollment period* from December 1972 through August 1973 for those people who first meet the eligibility requirements in or before May 1973. For people first meeting the requirement after that, however, the *initial enrollment period* will be a 7-month period beginning on the first day of the third month before the month of first eligibility and ending on the last day of the third month after the month of first eligibility. A *general enrollment* period will be held January 1 through March 31 of each year. No one will be able to enroll in hospital insurance more than twice. States or other public or private agencies or organizations may pay the premiums on a group basis for their active or retired employees age 65 and over.

Coverage for the aged who enroll during the *initial general enrollment period* will begin either (1) the first day of the 2nd month after the month of enrollment; or (2) July 1, 1973; or (3) the first day of the month in which all the eligibility requirements are met; whichever is the latest. For people who enroll during their *initial enrollment period,* the hospital insurance coverage will be effective according to the same timetable that is used for supplementary medical insurance. HI coverage begins the following July for those who enroll during a *general enrollment period.*

Coverage terminates (1) with the month of death; or (2) at the end of the month following the month in which the enrollee requests termination of his HI; or (3) at the end of the grace period provided for payment of overdue premiums (not to exceed 90 days without good cause); or (4) at the time the enrollee becomes eligible to HI based on credit for covered employment or as a dependent of a fully-insured person; or (5) at the time the enrollee's SMI entitlement ends.

Q. *How long will the premium remain $33?*

A. At least through June 1974. Any change in the premium amount will be announced during the last calendar quarter of each year, beginning in 1973, and would be effective the following July. Any premium increase or decrease will be recomputed in the same proportion as the inpatient hospital deductible and in multiples of $1. (As with SMI, 10 percent per year additional will be charged for late enrollment.)

Q. *What is the citizenship and residency test?*

A. It is the same one that applies to enrollees in SMI. The enrollee must be a resident of the U.S. and either a U.S. citizen or an alien lawfully admitted for permanent residence who has continually resided in the U.S. throughout the immediately preceeding 5 years.

Q. *Why are enrollees for HI required to enroll in SMI also?*

A. This requirement reduces the possibility that excessive utilization of the more expensive HI coverage might occur if the beneficiary were not covered under SMI.

CHART 4

EXTENSIONS OF COVERAGE

Effective: January 1973

MEDICARE OUTSIDE THE U.S.

NON-EMERGENCY

- INPATIENT HOSPITAL SERVICES
- RELATED PHYSICIANS' AND AMBULANCE SERVICES

COVERED FOR BENEFICIARIES RESIDING NEAR BORDERS, WHERE FOREIGN HOSPITAL MORE ACCESSIBLE

EMERGENCY

- INPATIENT HOSPITAL SERVICES
- RELATED PHYSICIANS' AND AMBULANCE SERVICES

COVERED FOR BENEFICIARIES TRAVELING DIRECTLY BETWEEN ALASKA AND ANOTHER STATE

Medicare Outside the U.S.

The amendments broaden Medicare coverage to include *non-emergency* (as well as emergency) inpatient hospital services outside the U.S. and the physicians' and ambulance services furnished in connection with such hospitalization. These benefits are payable only to a beneficiary who is a U.S. resident, when the foreign hospital is closer to, or substantially more accessible from, his residence than the nearest suitable U.S. hospital available for his treatment.

The amendments also extend Medicare coverage to *emergency* inpatient hospital services and related physicians' and ambulance services needed by beneficiaries while traveling in Canada between Alaska and another continental State. Such beneficiaries must be traveling without unreasonable delay by the most direct route. The hospital must be closer to, or substantially more accessible from, the site where the emergency occurred than the nearest adequately equipped available U.S. hospital.

Under prior law still in effect, *emergency* inpatient services provided in nearby foreign hospitals are covered if the beneficiary is physically present in the U.S. when the emergency arises and the foreign hospital is closer or more accessible than the nearest available U.S. hospital that is adequately equipped to deal with the beneficiary's ailment. Physicians' and ambulance services related to such hospitalization also are covered.

The non-emergency services covered by Medicare outside the U.S. will be of considerable value to a beneficiary who lives so close to the Mexican or Canadian border that the nearest hospital to him is in Mexico or Canada. Under prior law, such a person could not receive Medicare benefits for non-emergency hospital care he received in a foreign hospital, even though he may have used the foreign hospital and physicians routinely for his non-emergency care. The non-emergency benefits are limited to border residents, since one of the requirements is that the foreign hospital must be closer to or more accessible from the beneficiary's residence than a suitably equipped U.S. hospital. Similarly, the additional coverage of emergency services in Canada can be of great value to beneficiaries traveling directly between Alaska and another continental State who require emergency health care enroute.

The physicians' care that may be covered under this amendment must be rendered during the time the beneficiary is receiving covered inpatient hospital care. Similarly, the ambulance services that may be covered must be furnished in conjunction with the inpatient hospital services. Payment for physicians' and ambulance services will be based on itemized bills, as provided under present law. Because of administrative difficulties in applying it, the assignment method of reimbursement will not be used.

Benefits related to claims for non-emergency services will be payable only with respect to inpatient care in foreign hospitals that have been accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by a hospital-approval program with standards essentially comparable to JCAH.

Payment for all covered hospital services furnished outside the United States will be made essentially on the same basis as payment for emergency services furnished by a nonparticipating hospital within the United States: Hospitals that elect to bill Medicare will be reimbursed on the basis of the reasonable cost of the covered services furnished the beneficiary; if the hospital does not elect to bill Medicare or does not furnish cost data, benefits may be paid directly to the beneficiary on the basis of an itemized bill. Subject to the appropriate deductibles and coinsurance, the beneficiary will be reimbursed 60 percent of the hospital's reasonable charges for "routine services" in the room occupied by him or in semi-private accommodations, whichever is less, plus 80 percent of the hospital's reasonable charges for "ancillary services." If the hospital does not make separate charges for routine and ancillary services, reimbursement will be two-thirds of the hospital's total charges.

These changes apply to hospital admissions after 1972.

Q. *Who are considered to be "physicians?"*

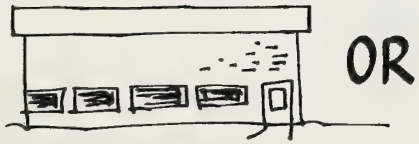
A. Any doctor of one of the arts recognized as a physician for Medicare purposes within the United States, subject to the same conditions and limitations. The foreign physician must be legally authorized to practice in the country in which the inpatient hospital services are furnished.

EXTENSIONS OF COVERAGE

PHYSICAL THERAPY SERVICES

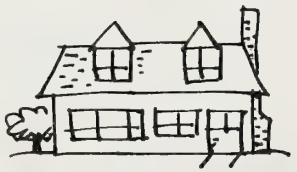
Effective: 7/1/73

A Physical Therapist in independent practice may provide covered outpatient physical therapy in –



HIS OFFICE

OR



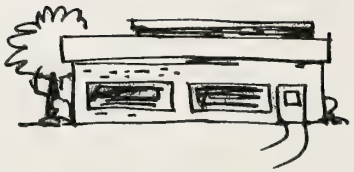
PATIENT'S HOME

$100 LIMIT ON INCURRED EXPENSES DURING A CALENDAR YEAR

Effective: 10/30/72

HOSPITAL

AND



SNF

CAN NOW FURNISH OUTPATIENT PHYSICAL THERAPY TO THEIR OWN INPATIENTS

Physical Therapy Services

Beginning July 1, 1973, the amendment broadens the coverage under supplementary medical insurance of outpatient physical therapy to include the home and office services of the physical therapist in independent practice. Such physical therapist must meet licensing and other standards prescribed by the Secretary in regulations. In addition, the services would have to be furnished under such conditions relating to health and safety as the Secretary may find necessary. Incurred expenses for these services could not exceed $100 in a calendar year. Payment for the reasonable charges for the covered services, less coinsurance and any deductible amounts due, would be made either to the beneficiary or, on assignment, directly to the physical therapist.

This extension of covered services to the therapist's office or the beneficiary's place of residence is designed to make physical therapy services more accessible to the beneficiary than under the present coverages. The concern of the Congress about the increasing cost of physical and other therapy services led to the inclusion of the $100 limitation.

Coverage of a self-employed physical therapist in independent practice, under the conditions specified, provides benefits for services which many beneficiaries require and for which, under prior law, coverage sometimes was dependent primarily upon where the therapy was given. For example, under prior law the services of a physical therapist in independent practice working under an arrangement with and under the supervision of a clinic were covered when furnished on the clinic's premises, but not covered if those same patients received the services in the therapist's office (which often is more accessible for beneficiaries than the facility). The amendment provides coverage of outpatient physical therapy in the therapist's office or the patient's home under a physician's plan.

Effective October 30, 1972, the new law also authorizes a participating hospital or skilled nursing facility to provide outpatient physical therapy services to its inpatients, so that an inpatient could conveniently receive these services after his inpatient benefits have expired or if he is not eligible for hospital insurance benefits. Under prior law, situations arose where inpatients of hospitals and skilled nursing facilities needed physical therapy services but had used up their inpatient benefit or for other reasons were not entitled to have payment made under HI. In order for such inpatients to receive covered physical therapy services without leaving the hospital or skilled nursing facility, it was necessary for the facility to arrange for an outside provider of physical therapy to treat the patient. While the new law eliminates this situation, it does not change the outpatient requirements with regard to other providers. Thus, providers of outpatient physical therapy services having inpatient facilities other than hospitals and skilled nursing facilities may not furnish covered outpatient therapy services to their own inpatients.

With one exception, the amendments have not altered the requirements for the content of the physician certification and/or recertification statement for outpatient physical therapy services. While the requirement that the physician certification must state that the physical therapy services are or were required by the patient is retained, the statement that they were required "on an outpatient basis" has been deleted.

Effective with cost reporting periods beginning on or after January 1, 1973, reimbursement for the reasonable cost of physical and other therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a home health agency under arrangements with others will be limited to amounts equivalent to the salary and other costs that would have been incurred by a provider if the services had been performed in an employment relationship, plus other costs an individual not working as an employee might have, such as maintaining an office, travel expenses, and similar costs.

EXTENSIONS OF COVERAGE

Effective: January 1973

SMI COVERAGE OF OUTPATIENT SPEECH PATHOLOGY

SERVICES FURNISHED BY PARTICIPATING:

- HOSPITALS
- SKILLED NURSING FACILITIES
- HOME HEALTH AGENCIES
- CLINICS
- REHABILITATION AGENCIES
- PUBLIC HEALTH AGENCIES

MAY BE COVERED IF FURNISHED:

1. IN PATIENT'S HOME
2. IN PROVIDER'S OUTPATIENT DEPARTMENT
3. TO INPATIENTS OF OTHER HEALTH FACILITIES
4. TO THEIR OWN INPATIENTS BY HOSPITALS OR SKILLED NURSING FACILITIES

SMI Coverage of Outpatient Speech Pathology Services Expanded

The amendments provide coverage under the supplementary medical insurance part of Medicare of speech pathology services (the same services referred to as speech therapy elsewhere in the law) furnished to beneficiaries on an outpatient basis by or under arrangements made by participating hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, clinics, and public health agencies, without requiring direct physician supervision of such services. Under prior law, individuals who were not eligible for home health benefits could secure outpatient speech pathology services only if provided as incident to a physican's service either in the physician's office or in the outpatient department of a hospital.

Payment will be made for outpatient speech pathology services only where a physician certifies that (1) such services are or were required because the individual needed speech pathology services, (2) a plan for furnishing such services has been established, and (3) such services are or were furnished while the individual is or was under the care of a physician.

The provider of services will be reimbursed for these speech pathology services by the hospital insurance intermediary (except where services are furnished by a clinic, reimbursement will be made by the SMI carrier). The patient will be responsible only for the regular SMI deductible and coinsurance amounts (i.e., the annual $60 deductible and 20 percent coinsurance).

Q. *Does a home health patient have a choice of whether to use home health SMI visits or the outpatient speech pathology benefit?*

A. Yes, providing he has SMI coverage.

CHART 7

EXTENSIONS OF COVERAGE

Effective: July 1973

LIMITED CHIROPRACTORS' SERVICES COVERED

- COVERED:

  MANUAL MANIPULATION FOR SUBLUXATIONS OF THE SPINE DEMONSTRABLE BY X-RAY

- NOT COVERED:

  ANY OTHER TREATMENT

Limited Chiropractors' Services Covered

Under prior law, services of chiropractors were not covered under Medicare.

Effective July 1, 1973, a licensed chiropractor or one who is otherwise legally authorized to practice chiropractic and who meets uniform minimum standards to be established by the Secretary of Health, Education, and Welfare is included in the definition of "physician" under Medicare. However, he is a "physician" only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray. The limited coverage recognizes the need for controls on the quality, cost, and utilization of chiropractic services.

CHART 8

EXTENSIONS OF COVERAGE

Effective 10/30/72

SUPPLIES RELATED TO COLOSTOMIES

- IRRIGATION AND FLUSHING EQUIPMENT AND OTHER SUPPLIES COVERED BY SMI
- ONLY BAGS AND STRAPS WERE COVERED BEFORE

Supplies Related to Colostomies

Under prior law, colostomy bags and necessary accoutrements required for attachment were covered as surgical dressings. The amendments now cover these items as prosthetic devices and extend this benefit to irrigation and flushing equipment and other items and supplies directly related to colostomy care whether or not the attachment of a bag is required.

This change is effective with respect to claims for items furnished on or after October 30, 1972.

CHART 9

BENEFICIARY ASSURANCE

Effective: 1/1/73

LEVEL-OF-CARE REQUIREMENTS IN SKILLED NURSING FACILITIES

- DEFINITION OF COVERED EXTENDED CARE SERVICES LIBERALIZED
- PRINCIPAL CHANGE: PATIENTS WHO REQUIRE DAILY SKILLED REHABILITATION SERVICES ON AN INPATIENT BASIS -- BUT DO NOT REQUIRE SKILLED NURSING SERVICES -- MAY BE COVERED
- SAME REQUIREMENTS APPLY TO MEDICAID

Level-of-Care Requirements in Skilled Nursing Facilities

The amendments liberalize the level-of-care requirements for covered posthospital extended care services and make the same requirements apply to skilled nursing facility services under Medicaid. The common level-of-care definition under both programs assures that benefits are paid on behalf of those patients who can best utilize the skilled types of services available in skilled nursing facilities. (See chart 43 for a description of the uniform standards for extended care facilities under Medicare and for skilled nursing homes under Medicaid, which have been redesignated as "skilled nursing facilities" (SNF's) for both programs.)

The services covered are those services provided directly by, or requiring the supervision of, skilled nursing personnel, or skilled rehabilitation services, which the patient needs on a daily basis, and which as a practical matter can only be provided in an SNF on an inpatient basis. Coverage will also continue during short periods when no skilled services are actually provided but when discharge from the SNF for such a brief period is neither desirable nor practical.

Skilled nursing services include assessment of the total needs of the patient, planning and managing a patient care plan, observation and monitoring of the patient's response to care and treatment, and rendering or supervising the rendering of direct services to the patient where the ability to provide the services or supervise the provision of the services requires specialized training. A patient who needs a variety of unskilled services on a daily basis could be considered a skilled care patient if the planning and overseeing of those services requires regular daily involvement of skilled personnel.

Skilled rehabilitation services include those skilled services that are essential to patients' rehabilitation and recovery and those services that are necessary to prevent deterioration of a patient's condition and sustain the patient's current capacities even when full recovery or medical improvement is not imminent. Since the principal aspect of covered care relates to the skilled services being rendered, the restorative potential of the patient is not controlling. The controlling factor is the skill and frequency of the services involved and the supervision that the patient requires.

This provision applies to services furnished after December 31, 1972. An estimated additional $90 million in extended care benefits will be paid during the first full year of operation.

Q. *What is an example of a condition which requires skilled rehabilitation services but not skilled nursing services?*

A. A hip fracture where the patient requires daily physical therapy services after the fracture has healed to the weight-bearing stage. Another example is a non-ambulatory stroke patient who only needs daily skilled rehabilitation services such as speech therapy.

CHART 10

BENEFICIARY ASSURANCE

Effective : 10/30/72

WAIVER OF BENEFICIARY AND PROVIDER LIABILITY IN DISALLOWED CLAIMS WHERE SERVICES ARE NOT MEDICALLY NECESSARY OR NOT A COVERED LEVEL OF CARE

Who knew or could be expected to know that the items or services furnished were not covered ?

NEITHER THE PROVIDER NOR BENEFICIARY →	MEDICARE IS LIABLE
THE PROVIDER →	PROVIDER IS LIABLE (and has appeal rights)
THE BENEFICIARY →	BENEFICIARY IS LIABLE (and has appeal rights)

Waiver of Beneficiary and Provider Liability in Disallowed Claims Where Services are Not Medically Necessary or Not a Covered Level of Care

Under prior law, whenever a Medicare claim was disallowed, the ultimate liability for payment for services fell upon the beneficiary. This was true even where the program had paid the claim and subsequently reopened and disallowed it. The result was that in many cases a beneficiary was liable for payment even though he acted in good faith and did not know that the services he received were not covered, and even though the hospital, physician, or other provider of services was at fault. Some beneficiaries—particularly those who received a non-covered level of extended care—suffered considerable financial hardship.

The amendments protect the beneficiary where claims were disallowed (1) because the expenses were incurred for services which were not reasonable or necessary for the diagnosis or treatment of an illness or injury, (2) where the expenses were for custodial care, and (3) when the beneficiary was without fault. In such situations the liability would shift either to the Government or to the provider—depending upon whether the provider utilized due care in applying Medicare policy in his dealings with the beneficiary and the Government.

Where both the provider and beneficiary exercised due care (i.e., they did not know, and had no reason to know, that noncovered services were involved), the liability shifts to the Government and payment will be made. However, in making such a payment, the provider and patient are put on notice that the service was noncovered with the result that in subsequent cases involving similar situations and further stays or treatments in the given case (or similar types of cases in the instance of the provider) they cannot show they had exercised due care. Thus, the Government's liability is progressively limited.

Where the provider did not exercise due care, but there was good faith on the part of the beneficiary, liability shifts to the provider. The provider is told that he can appeal the intermediary's decision both as to coverage of the services and due care. If, on the other hand, he exercised his rights under State law and received reimbursement from the beneficiary, the program in turn indemnifies the beneficiary (subject to deductibles and coinsurance). The indemnification is then treated as an overpayment against the provider and recovery is made from amounts otherwise payable to the provider.

Where the beneficiary was aware, or should have been aware, of the fact that the services were not covered, liability would remain with the beneficiary and the provider could either exercise his rights under State law to collect for the services furnished or appeal the determination through the SSA appeals process.

This provision is effective with respect to items or services furnished on or after October 30, 1972.

CHART 11

BENEFICIARY ASSURANCE

Effective: January 1973

ADVANCE APPROVAL OF POST-HOSPITAL EXTENDED CARE AND HOME HEALTH COVERAGE

- REGULATIONS WILL SPECIFY, BY MEDICAL CONDITION, LIMITED PERIODS OF STAY OR NUMBER OF VISITS WHICH WILL BE FOUND IN ADVANCE TO REQUIRE A COVERED LEVEL OF CARE, IF THE PHYSICIAN
  - Certifies that the patient's medical condition is one specified in regulations
  - Submits certification of medical need by time of admission or first visit
  - Submits a plan of treatment with the certification

Advance Approval of Post-Hospital Extended Care and Home Health Coverage

The Medicare law does not cover post-hospital extended care or home health care in all cases. *Extended care* is covered only if the beneficiary, who transfers from a hospital to a participating skilled nursing facility within a specified time after a covered hospital stay of at least 3 days, requires inpatient skilled services on a daily basis for a condition that was treated in the hospital. The coverage of post-hospital *home health care* is limited to cases in which the patient (who otherwise meets the requirement for these benefits) is under a physician's care, is confined to his home, and needs skilled nursing care on an intermittent basis, or physical or speech therapy. If these conditions are met, Medicare may cover a variety of other services—such as those of a home health aide, occupational therapist, medical social worker, etc.—furnished by the participating home health agency. Thus, the level of medical care that the beneficiary requires is a key factor in deciding whether the post-hospital care furnished by a skilled nursing facility or a home health agency is covered under the program.

Under prior law, determinations as to whether a beneficiary required the level of skilled care necessary to qualify for post-hospital extended care or home health care generally could not be made until sometime after the services were rendered. If the services were found not to be covered, the beneficiary often was faced with an unexpected large bill. The uncertainty about eligibility for these benefits tended to encourage physicians either to delay discharging a patient from the hospital (where coverage may have been questioned less frequently) or to recommend a less expensive non-participating nursing home where the services, while not covered by Medicare, could be afforded by the patient or his family. The effect was to reduce the value of Medicare's post-hospital extended care and home health care benefits as a continuation of care in less intensive—and more economical—settings that match the level of care with patients' medical needs.

This amendment authorizes "periods of presumed coverage"—limited lengths of stays in skilled nursing facilities or numbers of post-hospital home health visits—for designated medical conditions during which a patient would be presumed to be eligible for benefits. The medical conditions will be specified in regulations and will take into account such factors as the severity of such conditions, degree of incapacity, minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of services to be provided as the Secretary of Health, Education, and Welfare deems pertinent. For the advance approval procedure to apply, the physician's certification of need (already a condition of coverage in the law) must (a) be submitted before or at the time of admission to a skilled nursing facility—or prior to the first visit in the case of post-hospital home health care, (b) state that the medical condition of the individual is a condition designated in regulations, and (c) be accompanied by a plan of treatment for providing the services. Providers and Professional Standards Review Organizations (see chart 15) or intermediaries will be expected to monitor (through periodic reviews of a sample of paid stays, utilization review committee studies, and similar measures) the reliability of individual physicians in describing patients' conditions and certifying their needs for post-hospital care. The advance approval procedure can be suspended for those physicians who are found to be unreliable in this respect.

Not every possible type of medical condition with the necessary requirements can be shown in regulations, however. The medical conditions that would qualify will be limited, to the extent valid criteria can be established, to those which program experience indicates are the most appropriate for the purpose of advance approval. The approved period will not, in many cases, encompass the entire period that a patient may require covered care. The approved period should, however, provide sufficient time for a physician to make an evaluation of the patient's continuing need for covered care and, where additional coverage is requested, to submit the required evidence prior to termination of the approved period.

The above procedures are effective with skilled nursing facility admissions and home health plans initiated on or after January 1, 1973.

BENEFICIARY ASSURANCE

Effective: 10/30/72

MODIFICATION OF 14-DAY TRANSFER REQUIREMENT FOR EXTENDED CARE BENEFITS

- AFTER HOSPITAL STAY, IF SKILLED NURSING FACILITY ADMISSION IS DELAYED BECAUSE:

THERE IS A SHORTAGE OF APPROPRIATE BED SPACE--- Additional 14 days may be permitted	OR	IT IS MEDICALLY INAPPROPRIATE TO BEGIN ACTIVE COURSE OF TREATMENT--- Additional medically appropriate time may be permitted

Modification of 14-Day Transfer Requirement for Extended Care Benefits

Prior to the 1972 amendments, beneficiaries were entitled to extended care benefits only if they were transferred to a skilled nursing facility (and received a covered level of care) within 14 days after discharge from a hospital. In some cases that requirement could not be met because the patient's condition did not require the provision of skilled nursing care within the 14 days although such care may have been required at a later time. In other cases, the nonavailability of appropriate bed space in SNF's ordinarily used in the locality prevented admission within the 14 days. Denial of extended care benefits in such cases seemed inconsistent with the basic purpose of extended care—continuation of treatment begun in the hospital in a less intensive setting that matches the level of care with the patient's medical needs.

The amendments modify the 14-day transfer requirement in recognition of the problems that occurred in those situations. Where admission to a SNF within 14 days is prevented due to unavailability of bed space in the geographic area, the 14-day requirement is modified to provide that admission to a SNF within 28 days after hospital discharge will meet the transfer requirement. Where admission to a SNF within 14 days is prevented because the patient's medical condition does not permit provision of skilled services, such as physical therapy, within the 14 days, a longer period within which it is medically appropriate to begin active treatment will meet the transfer requirement.

This change was effective October 30, 1972.

Q. *What is an example of a situation where the patient's medical condition might prevent admission to a SNF within 14 days of hospital discharge?*

A. A patient with a hip fracture, who may require little in the way of skilled care for some time after his discharge from the hospital because the fracture will not have mended to the point where physical therapy and restorative nursing can be utilized.

BENEFICIARY ASSURANCE

Effective: 1/1/73

HOSPITAL ADMISSIONS FOR DENTAL SERVICES

- APPLIES TO HOSPITALIZATION FOR A NON-COVERED DENTAL PROCEDURE
- CERTIFICATION OF NEED FOR HOSPITALIZATION, IF REQUIRED, MAY BE MADE BY THE ATTENDING DENTIST

Hospital Admissions for Dental Services

If a Medicare beneficiary is hospitalized for a noncovered dental procedure, but the hospitalization is required to assure proper medical management, control, or treatment of a nondental impairment, the inpatient hospital services are covered.

Prior to the amendment, in some cases, intermediaries required that a physician certify to the medical necessity of such admissions. The amendment authorizes the dentist who is caring for the patient to make the certification under the above circumstances without a corroborating certification by a physician.

This provision is effective for hospital admissions after 1972.

CHART 14a

DELIVERY SYSTEMS MODIFICATIONS

Effective : July 1973

HEALTH MAINTENANCE ORGANIZATIONS

- HMO DEFINITION:
  ORGANIZATION PROVIDING HI AND SMI SERVICES, DIRECTLY OR THROUGH ARRANGEMENT, ON A PER CAPITA PREPAYMENT BASIS

- ALL MEDICARE BENEFICIARIES (ENTITLED TO HI AND SMI OR SMI ONLY) CAN ENROLL WITH AND RECEIVE THEIR HEALTH SERVICES FROM AN HMO IN THEIR AREA. MEDICARE WILL PAY THE CAPITATION PREMIUM FOR COVERED SERVICES

Health Maintenance Organizations

A Health Maintenance Organization (HMO) is an organization which provides to enrolled individuals, either directly or by arrangement with others, comprehensive health services on the basis of a predetermined periodic rate without regard to the frequency or extent of services furnished to a particular enrollee. To be an HMO for Medicare purposes, the organization must provide all the services and benefits covered under hospital insurance and medical insurance which are available to individuals residing in the geographic area served by the HMO.

Under the amendment, Medicare beneficiaries, eligible for HI and SMI, or only for SMI, can choose to have their covered health care provided through an HMO. The congressional intent is to provide Medicare beneficiaries the option of receiving services on an annual capitation basis from an HMO as an alternative to services under the traditional fee-for-service system.

Currently, group practice prepayment plans (GPPP's), which are the prototypes for HMO's, receive payments under Medicare, but the reimbursement procedure is complicated and the method of payment does not conform to their usual way of doing business. Thus the program does not directly benefit from the financial incentives such organizations have to keep costs low and control utilization of services. The new HMO option permits organizations providing comprehensive health services on a per capita prepayment basis to be reimbursed on a capitation basis for all Medicare services.

CHART 14 b

DELIVERY SYSTEMS MODIFICATIONS

Effective: July 1973

TYPES OF HMO'S

- "ESTABLISHED" HMO MUST
  - Provide all HI and SMI services--M.D.'s must be employees or partners of the HMO, or members of an M.D. group under arrangement with the HMO
  - Prove financial responsibility
  - Prove capability to provide quality services promptly
  - Have minimum enrollment of 25,000 *members, at least half of whom under age 65
  - Have been in operation at least 2 years
  - Provide annual open enrollment period
- "NEW" OR "DEVELOPING" HMO MUST MEET MORE FLEXIBLE CONDITIONS THROUGH REGULATIONS TO BE SET BY SECRETARY OF HEW

* Exception: Nonurban areas

Types of HMO's

An "established" HMO must have an enrollment of at least 25,000 members, not more than half of whom may be over age 65, and must have operated for at least 2 years. Exceptions to the 25,000 minimum enrollment could occur in sparsely settled areas contingent on the finding by the Secretary that the HMO (1) has at least 5,000 members, (2) has effective referral mechanisms to assure appropriate specialty services for its members, and (3) has 3 years of operating experience.

The organization must prove its financial responsibility and its ability to provide quality health care promptly and in an appropriate manner. Physician services must be provided either directly through physicians who are HMO employees or partners, or under arrangements with a group of physicians reimbursed on the basis of an aggregate fixed sum or on a per capita basis. (The group, however, may pay its physicians on any basis, including fee-for-service.)

"New or developing" HMO's (generally, HMO's with less than 2 years' operating experience) will not have to meet all of the standards required of established HMO's. For example, a new HMO would not be required to provide a comprehensive benefit package. The Secretary of Health, Education, and Welfare will issue regulations defining conditions these HMO's must meet. Of course, both established and new HMO's are required to meet those conditions of participation or other quality standards that apply to Medicare providers of health services outside of an HMO arrangement.

DELIVERY SYSTEMS MODIFICATIONS
HMO REIMBURSEMENT

- **INCENTIVE REIMBURSEMENT**
  - Limited to established HMO'S
  - Incentive payment amount is one-half of the HMO'S "savings" (difference between the HMO'S adjusted cost of providing services and the average per capita costs of area people not enrolled in the HMO)
  - Incentive payment cannot exceed 10 percent of adjusted average per capita costs
  - No Federal sharing of any losses
  - Beneficiary members in general must use HMO as single source of services
- **COST REIMBURSEMENT**
  - Applicable to new and developing HMO'S, but also may be used by established HMO'S
  - Interim monthly payments based on capitation
  - Annual adjustment to reflect actual reasonable cost
  - Beneficiaries may use outside sources

HMO Reimbursement

The amendments establish two types of HMO reimbursement—incentive reimbursement and cost reimbursement. Whether an HMO is established or new or developing has a bearing on the type of reimbursement procedure that will be applicable under Medicare. Incentive reimbursement may be used only by established HMO's, although an established HMO may elect to use cost reimbursement. The type of reimbursement an HMO uses is important to the beneficiary because, in general, beneficiaries enrolled in incentive reimbursement HMO's will receive services covered by Medicare only through the HMO. Beneficiaries enrolled in cost reimbursement HMO's, on the other hand, could obtain Medicare covered services from sources other than the HMO.

Incentive reimbursement HMO's would operate "at risk" and Medicare payments would be made on an incentive capitation basis. This would permit the HMO and the Government to share according to a prescribed formula in any savings the HMO achieves relative to adjusted average per capita costs of covered health services received by beneficiaries in the area not enrolled in the HMO. Such incentive payments could not exceed, in any year, 10 percent of adjusted average per capita costs. The Government would not share in any losses. A beneficiary enrolled in an incentive reimbursement HMO would be required to use the HMO as his single source of covered services, except for emergency services and urgently needed services received when he was temporarily outside the HMO's service area.

A cost reimbursement HMO would receive interim monthly capitation payments based upon its estimated costs of providing covered services to its Medicare enrollees. Payment would be subject to adjustment at the end of the fiscal year reflecting the HMO's actual reasonable cost of Medicare covered services. This reimbursement provision was designed to give new or developing HMO's experience with the capitation payment mechanism but would tie the ultimate Medicare payment directly to actual costs. A beneficiary enrolled in an HMO receiving cost reimbursement would *not* be required to use the HMO as his single source of covered health care. Payment would be made by Medicare in the usual manner for services he received outside the HMO.

This provision will become effective with respect to services provided on or after July 1, 1973.

CHART 15a

DELIVERY SYSTEMS MODIFICATIONS

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO'S)

By January 1974, U.S. to be divided into areas each serviced by a PSRO

Initially, agreements with interested organizations not to exceed 2 years

Existing utilization review operations will act as backup during conditional period

PSRO'S must be nonprofit and composed of
- Licensed doctors of medicine or osteopathy
- Doctors must be from area serviced by PSRO

When PSRO proves its effectiveness, the Secretary can waive any or all review, certification, or similar activities of current review procedures

Professional Standards Review Organizations (PSRO's)

The Medicare program is designed to meet certain health care costs of the aged in a manner that encourages effective, efficient, and economical delivery of health care. Current law requires participating hospitals and skilled nursing facilities to have utilization review committees composed of professionals in the field of health care to review, on a sample or other basis, admissions, duration of stays, and the professional services furnished Medicare beneficiaries. Intermediaries and carriers have the responsibility of reviewing both HI and SMI claims to determine whether the services furnished are medically necessary and represent covered care for Medicare purposes. However, experience has shown that these review activities have been less effective than hoped for as a curb to unnecessary use of institutional care and services. As a result, the amendments provide for a new system of peer review to be performed by organizations called Professional Standards Review Organizations (PSRO's). All health services for which payment may be made under the Social Security Act, including services provided under Medicare, Medicaid, and the maternal and child health programs, will be subject to PSRO review.

Not later than January 1, 1974, the Secretary of Health, Education, and Welfare will divide the U.S. into appropriate PSRO areas. At the earliest possible time after designation of these areas, the Secretary will enter into agreements on a conditional basis with organizations that qualify as PSRO's. These conditional agreements cannot exceed 2 years—during which the PSRO's will develop and begin their review activities and capacities. During the conditional period, existing utilization review operations will continue in a backup and standby capacity in case a PSRO encounters difficulties or withdraws. In order to avoid duplication of functions and unnecessary review and control activities, the Secretary may waive any or all of the review, certification, or similar activities of utilization review teams of intermediaries and carriers where he finds that the PSRO's have effective review and control activities.

A PSRO must be a nonprofit professional association composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the area serviced by the organization. The membership must be open to all such physicians on a voluntary basis. Each area generally will contain a minimum of 300 practicing physicians and in most situations, many more. In smaller or more sparsely populated areas an entire State may be a PSRO area. The objective is to have a large number of practicing physicians in an area participate to assure broad, diverse, and objective representation in the PSRO. To assure that applicant organizations are truly representative, the Secretary is required to poll the practicing physicians in an area, at the request of 10 percent or more of such physicians, as to whether or not an organization represents them. If more than 50 percent of physicians responding to the poll indicate the organization is not representative, the Secretary cannot enter into an agreement with that organization.

Physician organizations or groupings will be completely free to undertake or decline the responsibilities of organizing a PSRO. Should they decline, the Secretary can, after January 1, 1976, seek alternative applicants from among other medical organizations, i.e., State and local health departments, medical schools, and carriers and intermediaries or other health insurers. In no case, however, can any organization be designated as a PSRO which does not have professional medical competence, since decisions with respect to the conduct or provision of care by a physician must be made by qualified physicians.

CHART 15 b

DELIVERY SYSTEMS MODIFICATIONS

PSRO CONCERNS

WITHIN PSRO'S PURVIEW

- Whether institutional services are
  - medically necessary and
  - in accordance with professional standards
- Whether patients receive services in settings that are compatible with the level of care required
- Whether elective institutional admissions are medically necessary

OUTSIDE PSRO PURVIEW

- Non-institutional services--unless authorized by the Secretary of HEW
- Reasonableness of charges, costs, or methods of payment
- Matters of managerial efficiency unless patterns of utilization are affected
- Christian Science practice

• PSRO'S WILL RECEIVE ASSISTANCE FROM

- DHEW
- State agencies
- Medical associations
- Carriers
- Intermediaries
- Existing institutional utilization review organizations

PSRO Concerns

The PSRO will be responsible, in its area, for assuring that services furnished in the institutional setting are (1) medically necessary and (2) provided in accordance with professional standards. (The Secretary must agree to an extension of responsibility before a PSRO may review services other than in an institutional setting.) Where medically appropriate, the PSRO will discourage the attending physician from placing his patient in a setting that provides and charges for a higher level of care than required by the patient.

The PSRO will not be involved with questions concerning the reasonableness of charges, costs, or methods of payment. Similarly, it will not be concerned with internal questions relating to matters of managerial efficiency in hospitals or skilled nursing facilities except to the extent that such questions substantially affect patterns of utilization. In addition, Christian Science practice is not included in this provision.

PSRO's will be required to review, on a regular basis, the patterns of services delivered to beneficiaries by individual health care institutions, and other data to evaluate the necessity, quality, and appropriateness of services for which payment may be made under the program. Where effective utilization review committees already exist the PSRO may utilize their services. PSRO's may also approve—in advance—the medical necessity of all elective institutional admissions for the purpose of determining whether such admissions will be covered. This is not intended to infringe on the attending physician's decisions on what is best for his patient (i.e., when should his patient be admitted and discharged from an institution), but is intended to eliminate program payment for unnecessary institutional care.

It is expected that the Secretary, in conjunction with various medical and other organizations (including State agencies, Medicare carriers and intermediaries, and medical associations) will assist the local PSRO's by providing them with model operational guides, profiles on medical care practices, etc.

DELIVERY SYSTEMS MODIFICATIONS

PSRO STATE AND NATIONAL COUNCILS; APPEALS

- STATE PROFESSIONAL REVIEW COUNCILS
  Established in States having at least 3 PSRO'S to
  - Coordinate State PSRO activities
  - Disseminate information to the PSRO'S
  - Review overall effectiveness
  - Reconsider certain claims denied by PSRO
- NATIONAL PROFESSIONAL REVIEW COUNCIL
  - Report to the Congress and Secretary of HEW on overall and area-by-area effectiveness of the review program
  - Recommend program improvements
- APPEALS
  - Initial reconsideration by PSRO
  - If $100 or more in question, further reconsideration by State Professional Review Council and Secretary of HEW
  - Judicial review if amount exceeds $1,000

PSRO State and National Councils; Appeals

In States having three or more PSRO's, Statewide professional standards review councils (and an advisory group to each council) will be established. A council will consist of one representative from each PSRO, two physicians selected by the State medical society and two by the State hospital association, and four persons selected by the Secretary as public representatives. The public representatives must be knowledgeable in health care; two must be selected from nominees recommended by the Governor of the State. The council will coordinate Statewide PSRO activities, disseminate information to them, and review overall operating effectiveness of the system.

A National council will also be set up to coordinate PSRO activities. It will consist of 11 physicians chosen by the Secretary from nominees of consumer groups, national organizations, and other interested parties. Its primary duty will be to report regularly to the Congress and the Secretary on the overall and area-by-area effectiveness of the review program and to offer recommendations for program improvement. The council will also arrange for the collection and distribution of data to State councils and local PSRO's.

Beneficiaries, providers, or practitioners may request reconsideration of a PSRO determination. If the amount in question is $100 or more, a review of the PSRO's reconsideration determination may be requested. Such review will be conducted by the State Professional Standards Review Council. If there is no State council or if the State council's decision is appealed, the Secretary will provide a review. Where the amount in question exceeds $1,000, the Secretary's final decision is subject to judicial review.

CHART 16

DELIVERY SYSTEMS MODIFICATIONS

Effective: 1/1/73

HEALTH PLANNING

PROVIDER

Spends more than $100,000 for plant or equipment

AND

HEALTH PLANNING AGENCY

Has recommended against this expenditure

THEN THE SECRETARY OF HEW

Can withhold that part of Medicare payment to the provider which represents depreciation, interest, and profit on that investment

Health Planning

Normally depreciation, interest, and (for profit-making providers) return on investment are reimbursed under the Medicare program as part of the cost of providing services to Medicare beneficiaries. However, substantial Federal money is being spent under the comprehensive health planning provisions of the Public Health Service Act to further health facility planning at the State and local levels. At the same time, Federal funds are being paid for health services furnished under Medicare, Medicaid, and maternal and child health programs without regard to whether the facilities providing the services are cooperating with health planning agencies.

This provision is intended to reduce duplication of health care facilities and to promote the expansion and modernization of these facilities on a rational and controlled basis.

This provision is effective with respect to obligations for capital expenditures incurred after 1972, or earlier if a State so requests.

Q. *Would a hospital be able to appeal the decision of a health planning agency?*

A. An adverse decision by a State Planning Agency may be appealed to an appropriate agency or individual at the State level.

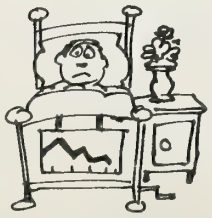
REIMBURSEMENT

Effective: 7/1/73

•SUPERVISORY PHYSICIANS IN TEACHING HOSPITALS

Payment for teaching physicians' services to non-private patients will be made on actual or equivalent cost basis

•REIMBURSEMENT PROCEDURES UNCHANGED FOR:



Private patients of such physicians

Hospitals that have billed all patients on a fee-for-service basis

Supervisory Physicians in Teaching Hospitals

Under this provision, reimbursement for teaching physicians' services to nonprivate patients will be made on a cost basis under the hospital insurance part of Medicare. Where the teaching physician donates his time and skills Medicare will make funds available to the hospital which are to be used for charitable or educational purposes. In determining the "equivalent cost" of the donated services the "average cost" salary of full-time salaried physicians will be applied to the actual time contributed by the teaching physician in direct nonprivate patient care or supervisory service.

A hospital will be permitted to include among its reimbursable costs the reasonable cost to a medical school of providing services to the hospital which, if provided by the hospital, would have been covered as hospital services.

Basing reimbursement for teaching physicians' services to nonprivate patients on an actual or equivalent cost basis, under HI, will mean that Medicare will pay its reasonable proportion of the cost for such services which, if not furnished, would have to be obtained through employed staff on a reimbursable basis.

Under prior law it was difficult to achieve equitable reimbursement of teaching physicians due to the large number of widely varying arrangements among hospitals, teaching physicians, and residents and interns. In some cases charges were billed where a supervising physician had overall responsibility for the actions of residents and interns even though he had not actually become involved in the patient's care. In other cases, charges for covered services were billed in amounts that were out of all proportion to the covered service or the charges billed to other patients.

The new provision does not apply to teaching physicians' services performed for private patients or to those hospitals which have traditionally billed all patients on a fee or package charge basis for professional services.

This provision is effective for accounting periods after June 1973.

REIMBURSEMENT

PREVAILING CHARGE INCREASES FOR MEDICAL AND OTHER HEALTH SERVICES

- PREVAILING RATE MAY NOT EXCEED 75th PERCENTILE OF ACTUAL CHARGES IN THE LOCALITY FOR SIMILAR SERVICES
- PREVAILING RATE MAY INCREASE ONLY TO THE EXTENT JUSTIFIED BY INCREASES IN LOCALITY EARNINGS AND PHYSICIANS' EXPENSES
- REASONABLE CHARGE FOR SPECIFIED MEDICAL SUPPLIES, EQUIPMENT, AND SERVICES MAY NOT EXCEED LOWEST CHARGE IN THE LOCALITY

Prevailing Charge Increases for Medical and Other Health Services

Under the law, payment for physicians' fees is computed as 80 percent of the "reasonable charge" for the physician's services (after the annual $60 deductible is met). The essential criteria for determining the reasonable charge are the individual physician's customary charge for the given service and the prevailing rate among physicians in the area for that service. (Also, for any service, the SMI carrier will not recognize for Medicare purposes a charge higher than would be applicable for a comparable service, rendered under comparable circumstances, to the carrier's own policyholders and subscribers.) The determination of what fees are "prevailing" for any given period requires a statistical analysis of fees for that period. Under Federal regulations first issued in January 1971, the prevailing rate has been defined as the 75th percentile of the range of charges for a particular service in a locality. The amendments make statutory the 75th percentile guideline. In brief, the prevailing rate for any service is intended to cover the full customary charges of those physicians whose billings are equal to, or less than, the 75th percentile of all billings in the area for that service. Where a patient goes to a physician whose charges for the service exceed that level—that is, are higher than those charged by his colleagues for 75 percent of similar services in the area—Medicare payment is based on the prevailing rate.

The amendments also make statutory a related guideline—previously spelled out only in regulations—that deals with how often the statistical compilations are updated in arriving at the customary and prevailing rates. Beginning July 1971, the figures for calendar year 1970 were used, with a corresponding progression at the beginning of each fiscal year thereafter. (Thus, reasonable charge determinations made by the carriers for the fiscal year beginning July 1972 are based on charge statistics for calendar year 1971.) There are several reasons for not updating the data more often. One is that a charge must be made over a reasonable time before it should be considered customary. Also, the statistical analysis itself takes time to accomplish. And, were Medicare to recognize increases in charges very quickly as they are made, there would be room for rapid escalation of the rates.

An additional element of the reasonable charge criteria is also included in the amendments. Beginning July 1973, increases in prevailing charge levels will be recognized only to the extent justified by indexes reflecting changes in the costs of practice of physicians and in earnings levels. Statistics on physicians' operating expenses and area earnings levels for 1971 will be compared with the similar figures for 1972. The expenses of practice absorb about 40 percent of gross receipts of practice of all self-employed physicians (the proportion indicated by IRS data). Thus, the maximum increase in prevailing charge levels that could be recognized would be 40 percent of any increase in the cost of practice plus 60 percent of any increase in earnings in the locality (as indicated by social security data). If, for example, during 1972 as compared with 1971, area increase in expenses is 3 percent and area increase in earnings is 5 percent, the allowable aggregate increase in prevailing charges recognized by the carrier would be 4.2 percent—$(.40 \times .03) + (.60 \times .05) = .042$. Tying the SMI recognition of fee increases to economic indexes that show other increases in the economy will mean SMI reimbursement will follow, rather than lead, inflationary trends.

Finally, the amendments set a limit on the amount of the charges that can be allowed as reasonable for medical supplies, equipment, and services (including equipment servicing) that generally do not vary significantly in quality from one supplier to another. The limit is the lowest level at which such supplies, equipment, and services are widely and consistently available in a locality. This provision is effective for charges incurred beginning in 1973.

REIMBURSEMENT

Effective: For accounting periods beginning after 1972

COSTS RECOGNIZED AS REASONABLE

- LIMITS ON COST TO BE RECOGNIZED AS REASONABLE SET IN ADVANCE
- LIMITS BASED ON COSTS INCURRED BY SIMILAR PROVIDERS IN THE LOCALITY
- PROVIDER CAN CHARGE PATIENTS FOR ADDITIONAL AMOUNT OVER THE COST LIMITS EXCEPT
  - For emergency care
  - When admitting physician has a financial interest in the facility

Costs Recognized as Reasonable

Some participating health care institutions incur higher costs than similar institutions in the locality because they furnish amenities in plush surroundings to their patients or because they are less efficient in delivering needed health care services. Prior law did not allow the cost reimbursement formulas to take these factors into account and, as a result, Medicare sometimes reimbursed unreasonably high hospital costs.

The amendments set forth additional guidelines on costs that can be recognized as reasonable. In general, these guidelines limit the amount of such costs to an amount that is not substantially out of line with other providers in the locality which are similar in size, scope of services, types of patients treated, and other economic factors.

The provider of services must be informed of such cost limits in advance so it will have the opportunity to avoid costs which are not reimbursable under the program. Where the patient is advised prior to admission of charges in excess of Medicare cost reimbursement levels, the institution may bill the patient directly for these charges. However, such billing is not allowable under the law for emergency care or when the admitting physician has a financial interest in the facility.

The new provision should encourage health care institutions to perform more efficiently. It is effective for accounting periods beginning after December 31, 1972.

Q. *If the only facility in an area is a luxury type institution, will this provision apply?*

A. No. If it were applied, additional charges could be imposed on beneficiaries who have no real opportunity to use a less expensive non-luxury institution.

CHART 20

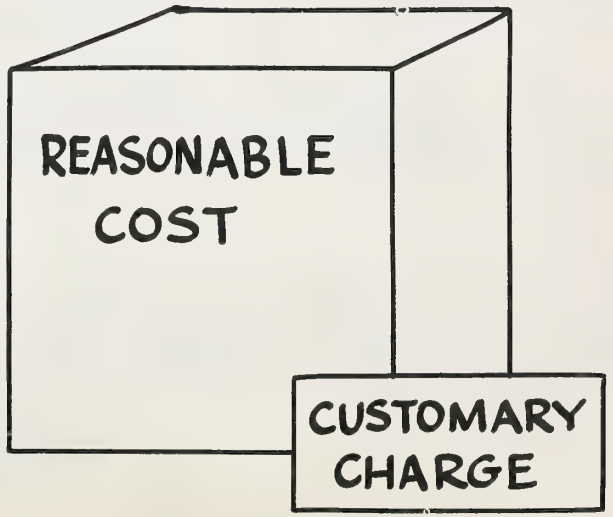
REIMBURSEMENT

Effective: With accounting periods beginning after 1972

PAYMENTS NO HIGHER THAN CHARGES

PROVIDERS WILL BE PAID EITHER:

- The reasonable cost of a service
- The customary charge



WHICHEVER IS LESS

Payments No Higher Than Charges

Reimbursement under Medicare is based on the reasonable cost incurred by providers of services (hospitals, skilled nursing facilities, and home health agencies) in providing services to Medicare beneficiaries. A relatively few providers customarily charge the general public less than the full cost of providing the services. (These providers usually make up the difference between their charges and costs from endowment or investment income.) This resulted, in some cases, in Medicare paying higher amounts for services received by beneficiaries than they would have been charged had they not been entitled to Medicare protection.

The amendments correct this inequitable situation by providing that Medicare payment, generally, may not exceed the customary charge made for covered services. For purposes of this provision, "customary charges" are those charges based on a charge schedule or the most frequently used charge for a specified service that is actually collected from a substantial number of patients.

This provision will not be applied to the services of public providers who furnish their services free or at a nominal fee. To ensure equitable treatment of these providers, fair compensation (which cannot exceed reasonable cost) will be made under Medicare. Nor will this provision apply immediately to any provider that charges less than its cost in a given period as a result of miscalculation or special circumstances of limited duration. Such providers will be permitted to carry unreimbursed allowable costs for that period forward for perhaps two succeeding fiscal periods. Should charges exceed costs during that time, those costs can be reimbursed along with the (then) current allowable costs.

This provision is effective with respect to services furnished in accounting periods beginning after December 31, 1972.

CHART 21

REIMBURSEMENT

REIMBURSEMENT RATES FOR SNF'S AND ICF'S

- BY 7/1/76 EACH STATE MUST DEVELOP A COST-RELATED FORMULA TO REIMBURSE SNF'S AND ICF'S UNDER MEDICAID
- FORMULAS NOT LIMITED TO MEDICARE REASONABLE COST FORMULA
- AFTERWARD, MEDICAID FORMULA WITH APPROPRIATE ADJUSTMENT COULD BE USED FOR MEDICARE REIMBURSEMENT

Reimbursement Rates for SNF's and ICF's

Under Medicare, skilled nursing facilities are reimbursed for the reasonable costs they incur in providing covered services to Medicare beneficiaries plus, in the case of proprietary institutions, an allowance related to net capital equity. Under Medicaid, States have been free to develop their own methods for reimbursing facilities providing skilled nursing and intermediate care services. States have generally established per diem rates for these purposes. The concern has been expressed that some Medicaid facilities are overpaid, and others are paid too little. On the other hand, the Medicare reasonable cost-finding requirements have been criticized as being too detailed, expensive, and cumbersome.

The amendment, therefore, requires that State Medicaid administrators develop methods patterned after the Medicare approach for reimbursing skilled nursing facilities and intermediate care facilities. However, States are not required to use the specific Medicare reasonable cost formula, although they will be free to choose this option. Rather, the States may develop other reasonable cost-related methods for rate-setting. These methods must be approved by the Secretary of Health, Education, and Welfare and ready for implementation under the Medicaid program by July 1, 1976.

The State payment rates developed for Medicaid purposes would then also be used for Medicare reimbursement purposes if rates could be appropriately adjusted to take into account specific factors related to Medicare (such as keeping a reasonable number of beds available, and additional administrative costs) which are not considered by the States or included in the computation of Medicaid rates.

REIMBURSEMENT

Effective: For cost reports for accounting periods ending on or after 6/30/73

REIMBURSEMENT APPEALS BY PROVIDERS

- PROVIDERS MAY APPEAL INTERMEDIARYS FINAL REASONABLE COST DETERMINATIONS OR THE FAILURE OF AN INTERMEDIARY TO MAKE A "TIMELY" DETERMINATION
- A PROVIDER REIMBURSEMENT REVIEW BOARD WILL BE ESTABLISHED TO HEAR DISPUTES
- AMOUNT IN CONTROVERSY MUST BE
  - $10,000 or more for one provider
  - $50,000 or more for a group of providers where dispute concerns common issues
- PROVIDERS HAVE RIGHT TO JUDICIAL REVIEW ONLY IF SECRETARY REVERSES BOARD DECISION

Reimbursement Appeals by Providers

The intermediaries under contract with the Government to process and pay hospital insurance claims also have the responsibility to determine the amount of reasonable cost incurred by providers of services. Although the Social Security Administration has established administrative procedures when providers disagree with the intermediaries about the amount, prior law did not contain a specific legislative provision for such appeals.

The amendments provide specific authority for appeals by providers regarding an intermediary's final reasonable cost determinations. The provision does not apply to questions of coverage or disputes involving individual beneficiary claims. A 5-man Provider Reimbursement Review Board will be established to review disputes concerning the intermediary's final determination (or failure to make a timely determination) on a provider's properly filed cost report where the amount in controversy is at least $10,000. Groups of providers can appeal to the Board on common issues where the amounts in controversy total $50,000 or more.

Decisions of the Board will be final unless the Secretary of Health, Education, and Welfare reverses or modifies the Board's decision within 60 days. In that case, the provider will have the right to judicial review.

This provision is effective with respect to cost reports for accounting periods ending on or after June 30, 1973.

CHART 23

REIMBURSEMENT

Effective: For accounting periods beginning after 12/31/72

PODIATRIC INTERNS AND RESIDENTS

- SERVICES FURNISHED UNDER APPROVED TEACHING PROGRAMS ARE REIMBURSABLE UNDER HOSPITAL INSURANCE

- COVERAGE IS COMPARABLE TO THAT OF INTERNS AND RESIDENTS UNDER APPROVED PROGRAMS FOR DOCTORS OF MEDICINE

Podiatric Interns and Residents

The amendments permit hospital insurance reimbursement on a cost basis for services furnished by an intern or resident in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association.

Prior law covered specified services of podiatrists but did not authorize reimbursement for services performed by participants in approved intern and residency programs in the field of podiatry. The change in the law removes an anomaly because, under prior law, services of other Medicare "physicians" performed under approved teaching programs in hospitals are reimbursed on a cost basis under hospital insurance.

The change is effective for accounting periods beginning after December 31, 1972.

CHART 24

REMAINING SMI CHANGES

Effective: 10/30/72

3-YEAR LIMIT ON ENROLLMENT ELIMINATED

- PRIOR 3-YEAR LIMIT ON INITIAL ENROLLMENT AND REENROLLMENT ELIMINATED
- LIMIT OF NO MORE THAN 2 ENROLLMENTS IS RETAINED

3-Year Limit on Enrollment Eliminated

Previously an individual could enroll in SMI during his initial enrollment period or—under prior law—during a general enrollment period which began within 3 years after either the end of his initial enrollment period or the termination of his first enrollment.

The 3-year limit was designed to avoid adverse selection if a very substantial proportion of people eligible for SMI deferred enrollment until they became ill. But, with 95 percent participation in SMI and with the vast majority of eligible people enrolling at the earliest possible time, there is no reason for the 3-year limit. Premiums are increased 10 percent for each full 12 months elapsed since the first time an individual could have first enrolled and actually does enroll. However, the months for which the law itself precluded individuals from enrolling do not apply in determining the late-enrollment charges. These late enrollment charges deter adverse selection and meet the higher costs associated with those who enroll at older ages.

The 1972 amendments eliminate the 3-year time limit on both initial enrollment and reenrollment after an initial termination. *The restriction limiting individuals to two enrollments as well as the provision for late enrollment charges are retained.* This provision applies to all those who are currently precluded from SMI enrollment because of the 3-year time limit, as well as to those individuals who in the future would have been ineligible to enroll under prior law because of the 3-year limit.

Individuals wishing to enroll must do so during the prescribed enrollment periods. The first such period under this change will be January 1, 1973-April 2, 1973, with coverage effective July 1, 1973.

REMAINING SMI CHANGES

Effective: January 1973

DEDUCTIBLE

- INCREASED FROM $50 TO $60 ANNUALLY
- BENEFICIARIES WILL CONTINUE TO PAY REASONABLY REPRESENTATIVE PORTION OF THEIR MEDICAL INSURANCE COSTS

Deductible

The amendments increase the amount of the supplementary medical insurance annual deductible from $50 to $60. Medical care costs have risen considerably since the Medicare program began and the increase in the SMI deductible means that beneficiaries will continue to pay a reasonably representative portion of their covered medical insurance costs. (An increase to $72, however, would have been necessary to maintain the same relationship between the deductible and total SMI costs as when Medicare began.)

The new deductible is effective with respect to covered services rendered on or after January 1, 1973.

CHART 26

REMAINING SMI CHANGES

Effective: Premiums payable as of July 1973

PREMIUM RATE

- AMOUNT PAYABLE BY AGED AND DISABLED WILL BE LIMITED
- PREMIUM INCREASE CAN'T EXCEED THE PERCENTAGE CASH BENEFITS HAVE INCREASED SINCE THE PREMIUM WAS LAST INCREASED
- TOTAL REMAINING SMI COST MET BY THE FEDERAL GENERAL REVENUES

Premium Rate

The amendments make a significant change in the way the amount of the supplementary medical insurance premium is established. Increases in the SMI premium amount payable by both the aged and disabled will be limited so that, in any given year, the premium will rise by no more than the percentage by which cash benefits had been increased in the interval since the premium was last increased. The premium amount, however, may never exceed one-half of the per capita cost of SMI for the aged. The total remaining cost of the SMI program will be met by the general funds of the U.S. Treasury.

Under prior law, people who signed up for SMI paid premiums that were computed so as to meet one-half of the total program cost. During the first 5 years of the program, however, it was necessary to increase the premium from $3.00 a month to $5.80—a 93 percent increase. If premiums were to have continued to rise in the future at such a rate, they would have become a severe financial burden to beneficiaries—people who generally are living on reduced incomes. Under the amendments, increases in premiums will be better related to beneficiaries' ability to meet the cost.

Premium rates will be announced during December of each year and will be effective for the fiscal year beginning the following July. (As of July 1, 1973, the SMI premium will be $6.30 per month.)

CHART 27

REMAINING SMI CHANGES

Effective: For accounting periods beginning after 1972

HOME HEALTH CARE COINSURANCE ELIMINATED

- ELIMINATING PRIOR 20% COINSURANCE FOR HOME HEALTH CARE UNDER SMI MAKES AMOUNT OF PAYMENT SAME UNDER SMI AND HI, AFTER SMI DEDUCTIBLE IS MET

Home Health Care Coinsurance Eliminated

Home health care may be covered under both the hospital insurance and supplementary medical insurance parts of Medicare. Under prior law, SMI paid only 80 percent of the reasonable cost for home health care covered under that part and the beneficiary was financially responsible for the remaining 20 percent. No such coinsurance applied to the post-hospital home health care covered under HI.

The amendments eliminate the home health care coinsurance under SMI, making the amount of payment for home health services (as defined in section 1861(m) of the law) the same under SMI and HI.

The $60 annual deductible continues to apply to home health services under SMI.

This change in the law will eliminate an expense of many SMI beneficiaries and will eliminate considerable beneficiary confusion. The change also reduces any incentive beneficiaries may have had to precede their needed home health care with hospitalization in order to qualify for coinsurance-free benefits.

The change will apply to home health services covered under SMI that are furnished by home health agencies after December 1972.

REMAINING SMI CHANGES

Effective: 10/30/72

PROSTHETIC LENSES ORDERED BY OPTOMETRISTS

- LICENSED OPTOMETRISTS MAY ATTEST TO THE NEED FOR PROSTHETIC LENSES (ONLY M.D.'s ORDER COULD BE ACCEPTED BEFORE)

- NO NEW TYPES OF SERVICES ARE COVERED

Prosthetic Lenses Ordered by Optometrists

Prosthetic lenses (eyeglasses or contact lenses that replace the natural lens of the eye, used most often after cataract surgery) are covered under SMI. Fitting and supplying the covered prosthetic lenses may be covered if performed by either a medical doctor or an optometrist. However, under prior law, the fitting and supplying of such lenses by an optometrist was covered only if a medical doctor had ordered or attested to the medical need for the prosthetic lenses.

Under the amendments, a doctor of optometry legally authorized to practice optometry by the State in which he performs such function becomes a "physician" as defined in the law but only for the purpose of attesting to the patient's need for prosthetic lenses. Thus, payment may be made for necessary prosthetic lenses whether prescribed by an optometrist or other physician authorized to do so. The amendment in no way changes the limitation on the coverage of optometric services. Accordingly, refractive services (procedures necessary to prescribe the correct lens power), whether performed by a physician or optometrist, continue to be excluded from coverage.

This change in the law does, however, recognize the ability of an optometrist to attest to a beneficiary's need for prosthetic lenses. The patient's choice of having either a medical doctor or an optometrist fit and supply such lenses will no longer be influenced by the prior-law requirement.

This provision applies to claims for prosthetic lenses furnished on or after October 30, 1972.

REMAINING SMI CHANGES

Effective: 10/30/72

REFUND OF EXCESS PREMIUMS

- IN DEATH CASES, EXCESS SMI AND/OR HI PREMIUMS WILL BE REFUNDED IN THE SAME MANNER AS UNPAID SMI BENEFITS
- LIST OF PRIORITIES:
  1. Person or persons who paid the premiums
  2. Legal representative of the estate
  3. Surviving spouse living with or entitled
  4. Entitled child or children
  5. Entitled parent or parents
  6. Surviving spouse not living with, not entitled
  7. Child or children not entitled
  8. Parent or parents not entitled

Refund of Excess Premiums

Under prior law, where Medicare entitlement terminated because of death, refund of any excess SMI premiums was made, upon claim, to the legal representative of the estate. A different procedure existed in the case where, for example, a SMI beneficiary paid his doctor's bill and died before reimbursement for his claim could be made.

The amendments eliminate the need for different overpayment procedures in such cases. The premiums paid in advance for both HI and SMI will be refunded in the same manner as any unpaid SMI benefits. The chart shows the list of priorities.

This change was effective October 30, 1972.

REMAINING SMI CHANGES

Effective: With respect to premiums due on or after 8/1/72

LONGER GRACE PERIOD FOR GOOD CAUSE

- SMI PROTECTION TERMINATES AFTER 90-DAY GRACE PERIOD FOR OVERDUE PREMIUMS -- EXCEPT

- GRACE PERIOD IS EXTENDED AN EXTRA 90 DAYS IF GOOD CAUSE EXISTS AND ENROLLEE PAYS PAST DUE PREMIUMS

Longer Grace Period for Good Cause

SMI enrollment is terminated for nonpayment of premiums. Under prior law, the termination was effective after a grace period of 90 days for payment of overdue premiums, regardless of the reason for nonpayment.

There have been cases where such termination was clearly inequitable. For example, for reasons of physical or mental incapacity, the enrollee was unable to pay premiums within the allotted time and no one was acting on his behalf to protect his interests. In other cases, coverage was terminated because the enrollee mistakenly believed that payment was made when actually it was not.

The 1972 amendments extend the 90-day grace period for an additional 90 days where the Secretary finds the enrollee had good cause for not paying the premium within the initial 90-day grace period.

This provision applies to cases for nonpayment of premiums which became payable on or after August 1, 1972.

CHART 31

REMAINING SMI CHANGES

Effective : March 1968

EXTENSION OF DEADLINE FOR FILING CLAIMS

- **LATE CLAIM WILL BE HONORED IF**
  - Failure to file timely is due to administrative error on part of DHEW or its agents
  - The claim is filed promptly once the error is corrected.

Extension of Deadline for Filing Claims

Benefit claims under SMI must be filed by December 31 of the year following the year in which the services were provided. (For this purpose, services furnished in the last 3 months of a year are deemed to have been furnished in the following year.) This time limit is adequate for the vast majority of SMI claims. In a few cases, however, timely claims were not filed due to administrative error of an officer, employee, intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under the Medicare program and within the scope of his authority. For example, misinformation from an official source or SSA's delay in establishing SMI entitlement has resulted in late filing of claims.

The 1972 amendments provide that where an SMI claim is not filed timely due to such an "administrative error," the claim may nevertheless be honored if filed as soon as possible after the facts in the case are established. This assures that claimants will not be treated inequitably because of such an error.

This provision applies to bills submitted and requests for payment made after March 1968.

REMAINING SMI CHANGES

Effective: 7/1/66

ENROLLMENT RIGHTS IN CASE OF GOVERNMENT ERROR OR INACTION

- EFFECTS OF ERRORS IN ESTABLISHING ENTITLEMENT MAY BE CORRECTED BY ESTABLISHMENT OF SPECIAL ENROLLMENT OR COVERAGE PERIODS, AND/OR APPROPRIATE PREMIUM ADJUSTMENTS
- EFFECTS OF ERRORS IN PREMIUM BILLING, WHERE ENTITLEMENT HAS BEEN PROPERLY ESTABLISHED, MAY BE CORRECTED BY WAIVING PAYMENT OF PAST DUE PREMIUMS

Enrollment Rights in Case of Government Error or Inaction

An individual may enroll in SMI during his 7-month initial enrollment period, which begins with the third month before the month he attains age 65, or during any general enrollment period.

There have been, however, relatively rare cases where due to the error, action, or inaction of the Federal Government, the individual's enrollment or nonenrollment is erroneous.

An example is a person who filed a timely enrollment request which was misfiled and not acted upon. When discovered, the person is sent a substantial bill for premiums or finds a benefit check reduced or withheld to pay retroactive SMI premiums even though he received no notice of coverage, award letter, HI card, or Handbook; had forgotten he filed; and did not use SMI benefits.

Conversely, an individual may execute a timely SMI withdrawal request that is not properly processed. He may subsequently receive a premium refund and be notified of an SMI overpayment for services in the period between retroactive termination and the date of belated notice.

Although not common, such cases involve people of advanced age, who are uncertain of SMI requirements and their cases cause hardship and distress. The automatic enrollment provision (see chart 33) is intended to eliminate many future problems; however, it is anticipated that cases will still occur where an individual is either enrolled or not enrolled contrary to his wishes.

Under the 1972 amendments, the Secretary may correct or eliminate the effects of these situations. This authority includes, but is not limited to, establishing special initial or subsequent enrollment periods, with SMI coverage determined on that basis, and with appropriate premium adjustments. In addition, where entitlement has been properly established but premium billing has not been properly initiated, past-due premiums may be waived.

This provision applies to all cases which have arisen since July 1, 1966, but no special search will be made for past cases.

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: Applies to people first eligible for SMI after 6/73

AUTOMATIC ENROLLMENT IN SMI

- PEOPLE AUTOMATICALLY ENROLLED UNLESS THEY SPECIFICALLY DECLINE COVERAGE
- SMI PROTECTION WILL BEGIN THE MONTH OF ENTITLEMENT TO HOSPITAL INSURANCE
- DOES NOT APPLY TO RESIDENTS OF FOREIGN COUNTRIES OR PUERTO RICO

Automatic Enrollment in SMI

Under prior law, an individual had to take positive action to enroll in SMI. Some eligible people failed to enroll on time because of inattention or, perhaps, because of difficulty in effectively managing their own affairs. This happened even though the concerted effort to notify people of their opportunity to enroll resulted in nearly 96 percent of eligible individuals enrolling. Most people who enrolled late lost several months of SMI coverage and some few were excluded from SMI altogether if they delayed too long. The Congress concluded it would be better to assure that aged and disabled individuals are enrolled unless they elect not to have the coverage.

Therefore, the amendments provide that the aged and disabled, except for residents of foreign countries and Puerto Rico, will be enrolled in SMI automatically as they become entitled to hospital insurance, unless they indicate they do not want SMI protection. A person eligible for automatic enrollment will be given the opportunity to decline the coverage and once coverage begins, will be free to disenroll if he wishes.

Persons already receiving monthly social security or railroad retirement benefits prior to age 65 will be deemed to have enrolled in (1) the month before the month they attain 65 or (2) the 24th consecutive month of entitlement to disability insurance benefits. Thus, their protection under both HI and SMI will start the following month. Such people who elect to decline coverage must do so before the end of the month described in (1) and (2) above in order to avoid a minimum of 4 months of SMI coverage.

Persons *not* already receiving monthly benefits will, if they have not established a prior SMI filing date, be deemed to have enrolled in SMI in the month they file for hospital insurance. Their SMI protection will begin according to the rules in prior law regarding when SMI protection begins.

This provision applies only to people who become entitled to hospital insurance after June 1973 or whose initial enrollment period begins after March 1973.

Q. *Why doesn't the automatic enrollment provision apply to residents of foreign countries or Puerto Rico?*

A. Because SMI does not cover services or items furnished outside the U.S., beneficiaries in foreign countries are protected only to the extent that they travel to the U.S. for treatment. The proportion of residents of Puerto Rico eligible for comprehensive health care under its Medicaid program is such that the general need for SMI coverage cannot be assumed. For members of both groups, then, automatic enrollment could work to their disadvantage.

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: 10/30/72

AUTHORITY TO TERMINATE PAYMENTS TO PROVIDERS AND SUPPLIERS OF SERVICES

If Providers or Suppliers are:

OVERCHARGING **OR** FURNISHING EXCESSIVE, INFERIOR, OR HARMFUL SERVICES **OR** MAKING FALSE STATEMENTS TO OBTAIN PAYMENT

The Secretary of Health, Education, and Welfare can:

PUBLISH THEIR NAMES *AND* TERMINATE OR SUSPEND THEIR FUTURE PAYMENTS AFTER REASONABLE NOTICE TO THEM AND THE PUBLIC

Authority to Terminate Payments to Providers and Suppliers of Services

Prior law did not give the Secretary authority to withhold future payments for services furnished by a participating institution, physician, or any other supplier who abuses the program.

Thus, for example, Medicare payment could be made to a beneficiary for services furnished by a physician found guilty of fraud, if the physician was legally authorized to practice.

The amendments give the Secretary authority to terminate or suspend program payment for services furnished by such providers and suppliers. Program review teams will be established in each State to furnish the Secretary professional advice in carrying out this authority.

The provision is intended to protect the Medicare, Medicaid, and maternal and child health programs and their beneficiaries from those suppliers of services who make a practice of overcharging; furnishing harmful, inferior, or excessive services; or engaging in fraudulent activities. The Secretary will make public the names of such persons or organizations so that beneficiaries will know which suppliers cannot participate in the program.

It is not expected that any large number of providers and suppliers will be suspended because of abuse. However, the authority and its use in even a relatively few cases is expected to provide a substantial deterrent to abuse.

This provision was effective October 30, 1972, with respect to Medicare, and is effective for items or services furnished after 1972 with respect to Medicaid and the maternal and child health programs.

Q. *Will providers and suppliers be able to appeal the Secretary's action?*

A. Yes. Any person or organization dissatisfied with the Secretary's decision to terminate payments will be entitled to a hearing and to judicial review of the Secretary's final decision.

CHART 35

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: 10/30/72

APPEAL PROCEDURES

- SMI

AMOUNT AT ISSUE MUST BE $100 OR MORE FOR A HEARING

- HI

AMOUNT AT ISSUE MUST BE--
- $100 OR MORE FOR A HEARING
- $1,000 OR MORE FOR JUDICIAL REVIEW

Appeal Procedures

SMI

A beneficiary who is not satisfied with the decision by a carrier on his claim for supplementary medical insurance benefits may secure, under current regulations, an impartial reconsideration review of the decision.

Under prior law, if the beneficiary was still dissatisfied after receiving the carrier's review decision, he had the right to request a "fair hearing" by a Hearing Officer of the carrier, regardless of the amount in controversy. Operating experience indicates that approximately 45 percent of the hearings conducted since 1965 have involved amounts at issue of less than $100, yet the cost of conducting a hearing often exceeds that amount.

The reconsideration reviews by the carriers are conducted under regulations that provide beneficiaries sufficient protection in small claims cases. Therefore, the Congress concluded that establishing a $100 minimum amount requirement for entitlement to a fair hearing would eliminate unwarranted costs and adequately protect the rights of beneficiaries.

The amendments clarify that there is no authorization for an appeal to the Secretary of Health, Education, and Welfare or to the courts on matters solely involving amounts of benefits under SMI. (This merely clarifies prior law; it does not change it.)

HI

The amendments specify that where the amount of benefits under the hospital insurance program is involved, a hearing is authorized only if the amount in controversy is $100 or more. Judicial review is authorized only if the amount in controversy is $1,000 or more.

These changes are effective with respect to appeal requests after October 30, 1972.

CHART 36

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: 10/30/72

OATHS AND AFFIRMATIONS IN MEDICARE CASES

- MAY NOW BE OBTAINED IN MEDICARE CASES
- HAD BEEN OBTAINABLE IN OASDI CASES

Oaths and Affirmations in Medicare Proceedings

SSA has the right to take affidavits under oath from beneficiaries, other witnesses, and principals in cases involving the old-age, survivors, and disability insurance programs. Under prior law, there was no similar right in cases involving Medicare. As a result, investigations of suspected program abuses were limited, since only statements (rather than affirmations or oaths) could be obtained.

The amendments correct this situation effective October 30, 1972.

CHART 37

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: No later than 1/1/73

PROHIBITION AGAINST REASSIGNMENT OF CLAIMS

- SMI BENEFITS MAY BE PAID ONLY TO THE ENROLLEE OR TO THE PHYSICIAN OR SUPPLIER WHO FURNISHED THE SERVICES EXCEPT THAT:
  - Payment may be made to the employer of the physician or supplier if the latter is required to turn over his fees to the employer.
  - Payment may be made to the facility where the services were provided if the facility has a contractual arrangement with the physician or supplier under which the facility bills for his services

Prohibition Against Reassignment of Claims

Under the SMI program, benefits for services furnished by a physician or other supplier of services are made to the enrollee on the basis of an itemized bill, or, on assignment, to the physician or other supplier of services. Previously since there was no specific provision in the law regarding reassignment by physicians or others, reassignments were honored in certain specified situations. Reassignments to some organizations created administrative problems in determining reasonable charges and recovering overpayments. The new provisions therefore prohibit payment of assigned benefits to anyone other than the physician or other person who furnished the services except:

1. to the employer of the person who furnished the services if such person is required as a condition of his employment to turn over his fees for the services to his employer, or
2. to a facility in which the services are provided if there is a contractual arrangement between the facility and the person furnishing the services under which the facility bills for the service.

This provision applies to claims under Medicare and Medicaid. It is effective with respect to bills submitted to Medicare on or after October 30, 1972. For Medicaid, the provision is effective no later than January 1, 1973.

CHART 38

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: 10/30/72

NEGOTIATED PAYMENT FOR LABORATORIES

- AUTHORIZES A NEGOTIATED PAYMENT RATE FOR ASSIGNED CLAIMS
- NO COINSURANCE WHEN PAYMENT ON NEGOTIATED RATE BASIS
- SOLVES PROBLEM OF LABORATORIES' COLLECTION COSTS BEING MORE THAN COINSURANCE AMOUNT.

Negotiated Payment for Laboratories

Diagnostic tests performed by Medicare certified independent laboratories may be covered under SMI. Under the established procedure, reimbursement is based on 80 percent of the reasonable charge for covered services, above any applicable portion of the annual $60 deductible. Payment may be made to the beneficiary or, if the laboratory accepts assignment, directly to the laboratory.

The costs of billing incurred by independent laboratories that bill patients directly for low cost diagnostic tests, rather than through physicians, are often disproportionately large. This is particularly so in assignment cases where the laboratories' costs of collection of the coinsurance amounts may exceed the coinsurance amounts being collected from the patients. This could cause some laboratories to increase their charges for Medicare purposes to collect the full fee from the program without billing the patient for the coinsurance.

To deal with this problem, the amendments authorize the Secretary of Health, Education, and Welfare to negotiate payment rates with laboratories which would be considered the full charges for such tests, for which Medicare reimbursement would be made at 100 percent of such negotiated rate.

This provision applies only to diagnostic laboratory tests for which payment is to be made to a laboratory on the basis of an assignment by the beneficiary. Further, the negotiated rates may not exceed the payments that would have been made in the absence of such rates.

The provision was effective October 30, 1972.

CHART 39

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective : For notices sent after 1968

LIMITATIONS ON ADJUSTMENT OR RECOVERY OF INCORRECT PAYMENTS

- **BENEFICIARIES WHO ARE WITHOUT FAULT WILL NOT BE HELD RESPONSIBLE FOR OVERPAYMENTS**
  - That result from services that were not medically necessary or represented a noncovered level of care
  - If payment was made 3 or more years previously
- **PROVIDERS, AND SUPPLIERS WHO ACCEPTED ASSIGNMENT, WHO REFUNDED OVERPAYMENTS FOR SUCH SERVICES MAY NOT CHARGE SUCH BENEFICIARIES AFTER 3 YEARS**
- **NO COLLECTION OF INCORRECTLY PAID BENEFITS WILL BE MADE FROM PROVIDERS AND SUPPLIERS AFTER 3 YEARS**

Limitations on Adjustment or Recovery of Incorrect Payments

Congress considered certain inequities that existed under prior law with respect to the recovery of incorrect payments under Medicare and approved provisions which place limits on such recovery. Under the amendments, a beneficiary will ordinarily be deemed to be without fault and will not be held responsible for an overpayment which results from services that were not medically necessary or represented a non-covered level of care if 3 years have elapsed since the payment was made. Further, no collection of incorrectly paid funds will be made from providers or suppliers when 3 years have passed after the year in which the incorrect payments were made to them.

The amendments also include a provision that prohibits providers of HI services (or physicians or other suppliers who accepted assignments under SMI) who refunded an overpayment for medically unnecessary or non-covered level of care services, after 3 years, from charging beneficiaries who are found to be without fault.

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: For overpayments outstanding on 10/30/72

WAIVER OF RECOVERY OF INCORRECT PAYMENTS FROM SURVIVORS

- RECOVERY OF OVERPAID MEDICARE BENEFITS MAY BE WAIVED IF
  - Survivor is without fault
  - Recovery would be against equity and good conscience

Waiver of Recovery of Incorrect Payments from Survivors

Where a survivor is liable for the repayment of a Medicare overpayment to a deceased beneficiary, the amendments permit waiver of recovery of the overpaid amount if the survivor is without fault in incurring the overpayment and if the recovery would be against equity and good conscience or would defeat the purposes of title II. (Only those survivors receiving monthly social security benefits on the deceased's earnings record are subject to recovery of overpayments.)

Under prior law, waiver of recovery was not permitted with respect to such survivors of overpaid individuals, even though the survivors were without fault. Situations had occurred where overpayments had to be recovered from the widow of the overpaid person, whereas if the overpayment had been made to or on behalf of the widow herself, waiver could have applied.

This provision applies to overpayments outstanding as of October 30, 1972.

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: March 1973

PREMIUM COLLECTION FROM PEOPLE ENTITLED TO BOTH SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

- RRB RESPONSIBLE FOR COLLECTING PREMIUMS FROM ALL BENEFICIARIES ENTITLED TO RAILROAD RETIREMENT AND SOCIAL SECURITY BENEFITS

Premium Collection from People Entitled to Both Social Security and Railroad Retirement Benefits

Under prior law, either SSA or the Railroad Retirement Board collected the SMI premiums from individuals who were entitled to both social security and railroad retirement benefits, depending on the circumstances of entitlement at the time of enrollment. This arrangement has caused administrative discrepancies—some beneficiaries, for example, enrolled twice and received two Medicare cards with different numbers. Although ultimately corrected, these discrepancies have caused beneficiary confusion and unnecessary administrative expense.

The amendments provide that RRB will collect the SMI premiums for all individuals entitled under that program (whether or not they are also entitled under social security). This change will eliminate some of the confusion, payment delay, and administrative expense related to the division of responsibility under prior law.

Also under this provision, the Railroad Retirement Board is granted the authority to contract with carriers to process SMI claims from its beneficiaries. This makes statutory an arrangement that has already been in effect.

The RRB will collect such premiums becoming due and payable beginning March 1973.

CHART 42

IMPROVEMENTS IN OPERATING EFFECTIVENESS

Effective: 10/30/72

- ROLE OF HIBAC MODIFIED

Role of HIBAC Modified

The amendments modify the role of the Health Insurance Benefits Advisory Council to that of advising the Secretary of Health, Education, and Welfare on matters of general policy in the administration of Medicare.

HIBAC had broader authority under prior law, since during the earlier years of Medicare the major policy features of the program had to be established. Now, there seems to be little need for permanent authority to deal with the often routine modifications and refinements in Medicare, in view of the program's present status and the development of administrative expertise and capabilities. The National Professional Standards Review Council (see chart 15c) will now evaluate utilization of health care services.

CHART 43

PROVIDERS AND SUPPLIERS

Effective: 7/1/73

UNIFORM MEDICARE AND MEDICAID STANDARDS FOR SKILLED NURSING FACILITIES

- CHANGES NAME OF

Medicare "Extended Care Facilites"
and
Medicaid "Skilled Nursing Homes"
to
"SKILLED NURSING FACILITIES"

- ESTABLISHES IDENTICAL STANDARDS FOR
  - Health
  - Safety
  - Staffing
  - Environment
  - Certification for Participation

- STRENGTHENS UNIFORM STATE ADMINISTRATION OF STANDARDS WITH RELIANCE ON FEDERAL REGULATIONS
- REDUCES DUPLICATIVE ACTIVITY AND RED TAPE

Uniform Medicare and Medicaid Standards for Skilled Nursing Facilities

The conditions of participation for extended care facilities under Medicare and the standards for skilled nursing homes under Medicaid are essentially the same (identical in some respects; similar in others), although there are differences in the way regulations governing participation in the two programs are interpreted and applied from State to State. For example, the Medicaid standards are somewhat less definitive and contain waiver provisions with respect to some requirements. Where State agencies administering Medicaid could waive compliance with specific provisions of the Life Safety Code of the National Fire Protection Association, or with certain conditions relating to sanitation, Medicare regulations required that higher standards be applicable to extended care facilities.

While the emphasis of the covered care in skilled nursing institutions under the two programs differs somewhat—Medicare focusing on the short-term care patient and Medicaid on the long-term care patient—patients in these facilities require essentially the same types of services. Indeed, not infrequently, after expiration of Medicare extended care benefits, the patient may remain in the same facility—even the same room—as a Medicaid recipient.

The amendment will require that institutions which receive Medicaid skilled nursing payments must meet the same health, safety, environmental, and staffing requirements applicable to ECF's under Medicare.

Of course, if higher standards are imposed for Medicaid purposes, they shall be made applicable for facilities rendering extended care services under Medicare. In effect the amendment strengthens the uniform administration of Medicaid standards by requiring more reliance on Federal regulations and restricting the application of all waivers to situations which have the approval of the Secretary of Health, Education, and Welfare. Facilities which satisfy the standards under one program (Medicare or Medicaid) would therefore be eligible to participate in the other if they agree to the terms of participation.

The amendment adds the following three Medicaid requirements, with modifications, to the present statutory Medicare requirements: that each skilled nursing facility (a) identify each person having an ownership interest of 10 percent or more, or of each partner, or director; (b) cooperate in an effective program of independent medical evaluation and audit of its patients; and (c) meet such provisions of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes and as are held to be appropriate by the Secretary.

To further reduce State to State variability, the Secretary now will decide whether a facility qualifies to participate as a skilled nursing facility in both the Medicare and Medicaid programs. Previously, this decision was split. Even though the facility wished to participate in both programs, Medicaid facility certification was within the jurisdiction of State officials and the Secretary's authority was limited to Medicare participating facilities. In the future, only those skilled nursing facilities wishing to participate in Medicaid only will be certified by State officials.

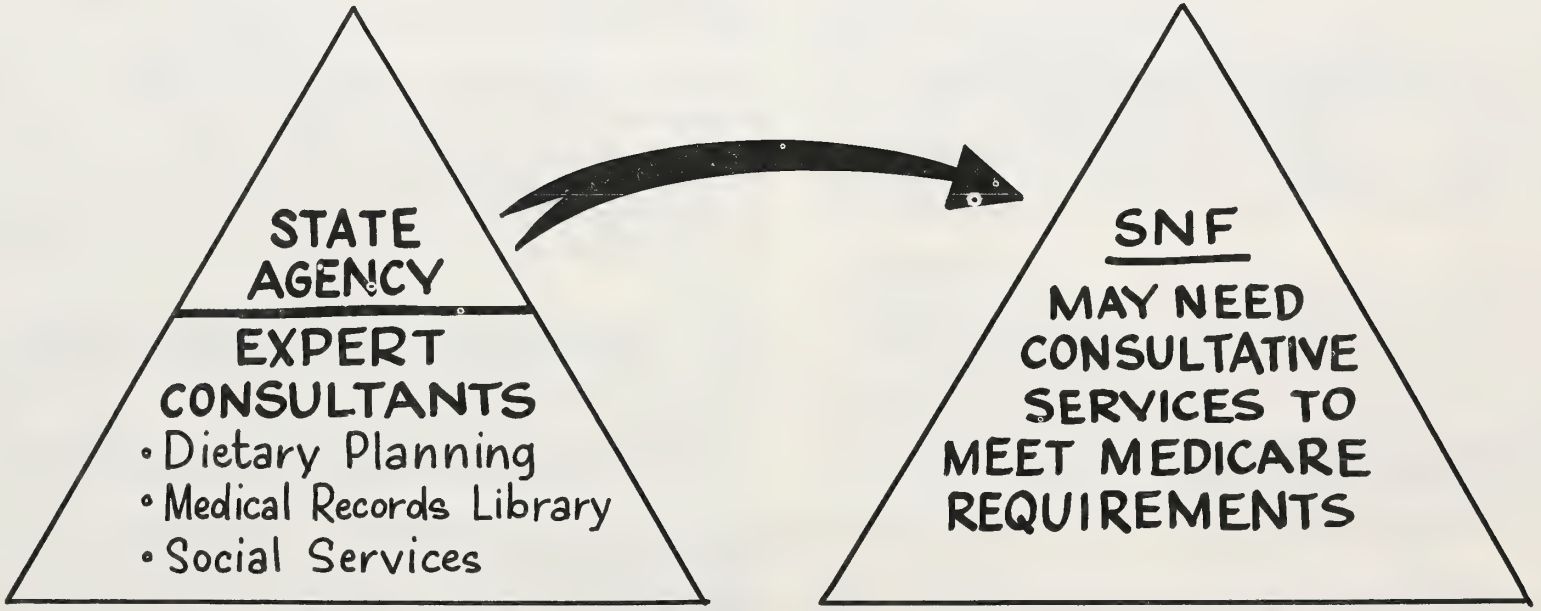
The amendment also establishes a new name to reflect the common set of standards for institutions formerly identified as extended care facilities under Medicare and as skilled nursing homes under Medicaid. The name of these institutions will now be "skilled nursing facilities." Therefore, in the future, "extended care benefits" under Medicare will be provided in "skilled nursing facilities."

The amendment is effective July 1, 1973.

PROVIDERS AND SUPPLIERS

Effective: 10/30/72

CONSULTANTS FOR SKILLED NURSING FACILITIES



RESULTS---

- SNF saves high fees of private consultants
- Medicare saves by paying cost of salaried State employees
- SNF remains in Medicare compliance, providing needed services to community

Consultants For Skilled Nursing Facilities

Among the conditions of participation for Medicare skilled nursing facilities is the requirement that these facilities have specialists on their staffs or retain consultants in certain areas, e.g., dietary service and maintenance of medical records. Reimbursement is made to each facility only for that portion of the costs of the consultant's services representing services provided to Medicare patients. In many areas of the country, such consultants are in short supply and the cost of retaining them on a per diem basis is often prohibitive for many skilled nursing facilities.

State health agencies regularly employ specialists who may be available to provide consultative services to skilled nursing facilities, thus enabling them to meet Medicare requirements. This amendment authorizes State agencies that are able and willing to do so, to furnish consultative services to facilities requesting them. Of course, the State's arrangements would be subject to the approval of the Secretary. Medicare payment would be made directly to the State agency for the costs of rendering the consultative services.

This amendment is expected to reduce costs to the Medicare program as the consultants would be salaried employees of the State. It should also lead to more effective use of scarce personnel. Finally, determination of compliance by a facility with Medicare requirements would be substantially simplified through verification at a single source—the State agency—rather than with scattered consultants.

CHART 45

PROVIDERS AND SUPPLIERS

Effective: 10/30/72

MEDICAL SOCIAL SERVICES IN SNF'S

- PROVIDING THE SERVICES OF A PROFESSIONAL SOCIAL WORKER IS NO LONGER REQUIRED AS A CONDITION FOR PARTICIPATION FOR SNF'S

- SUCH SERVICES STILL MAY BE COVERED IF PROVIDED

Medical Social Services in Skilled Nursing Facilities

Skilled nursing facilities providing extended care services have previously been required under the conditions of participation in Medcare to engage the services of a professional social worker. Such personnel are primarily responsible for discharge planning. Some facilities have had difficulty obtaining such consultants, and where available, they have been quite expensive.

To alleviate this problem, the Secretary of Health, Education, and Welfare may no longer require the provision of medical social services as a condition for participation for skilled nursing facilities. However, Medicare will continue to cover medical social services when they are furnished under conditions that meet the coverage requirements under prior law.

This provision was effective October 30, 1972.

PROVIDERS AND SUPPLIERS

Effective: 10/30/72

WAIVER OF REGISTERED NURSE REQUIREMENT IN RURAL SKILLED NURSING FACILITIES

- FULL TIME NURSING REQUIREMENT MAY BE WAIVED IF SUCH FACILITY EMPLOYS REGISTERED PROFESSIONAL NURSE FOR AT LEAST 40 HOURS OVER A 5-DAY PERIOD
- FACILITY MUST BE MAKING GOOD-FAITH EFFORT TO OBTAIN ADDITIONAL REGISTERED NURSE
- WAIVER POSSIBLE ONLY IF SNF
  - Has only patients who do not require services of an RN or physician for a 48-hour period, OR ---
  - Has made arrangements for an RN or physician to spend such time as is necessary at the SNF on days the regular full time RN is not on duty

Waiver of Registered Nurse Requirement in Rural Skilled Nursing Facilities

Previous law required a skilled nursing facility to provide 24-hour nursing service under the direction of a registered professional nurse who was employed full time. The amendments allow the Secretary of Health, Education, and Welfare to waive the requirement that an SNF must employ a registered nurse full time to the extent that "full time" is deemed to mean more than 40 hours a week.

There are some rural skilled nursing facilities which can obtain a registered nurse to work an 8-hour shift 5 days a week but are unable to obtain an additional registered nurse to work on the other 2 days, generally the weekend. The amendment recognizes the special staffing problems faced by SNF's in rural areas, but also safeguards the patient whose nursing needs warrant care by a registered nurse.

The change actually strengthens present law by construing "full-time" to mean 7 days a week. Therefore, in the future, the Secretary may waive the requirement if a rural skilled nursing facility employs one registered nurse for 40 hours over a 5-day period and is making good-faith efforts to obtain another. The waiver may be permitted only with respect to not more than 2 day shifts, such as over a weekend. The waiver may be authorized only if the SNF (1) has only patients whose physicians have indicated that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (2) has made arrangements for a registered professional nurse or a physician to spend such time at the SNF as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

This provision was effective October 30, 1972.

PROVIDERS AND SUPPLIERS

Effective: After 3/73

INSTITUTIONAL PLANNING

• NEW CONDITION OF PARTICIPATION FOR PROVIDERS

OPERATING BUDGET

- For upcoming accounting year
- Anticipated income and expense items (but not item-by-item components)

AND

CAPITAL EXPENDITURES PLAN

- For at least the next 3 year period
- Objectives of and anticipated financing for each planned expenditure over $100,000 for
  - Buying or improving land
  - Improving, modernizing, and expanding buildings and capital equipment

- UPDATED ANNUALLY
- PREPARED BY COMMITTEE
- NOT REVIEWED FOR SUBSTANCE BY THE GOVERNMENT

Institutional Planning

Beginning with fiscal years after March 1973, as a condition of participation under Medicare, hospitals, skilled nursing facilities, and home health agencies will be required to have a written overall plan including an operating budget and a capital expenditures plan which will be reviewed and updated annually. The operating budget would include all anticipated income and expense items for the upcoming accounting year. The capital expenditures plan would cover at least a 3-year period and would contain information regarding proposed capital expenditures in excess of $100,000 for acquisition or improvement of land, buildings, and equipment; replacement, modernization, and expansion of buildings and equipment; and proposed methods of financing the costs. The operating budget and capital expenditures plan will be prepared by a committee comprised of members of the provider's medical staff (if any), administrative staff, and representatives of the governing body.

The plan will not be reviewed for substance by the Government or any of its agents. Nor will the Government play any role in the planning and budgeting process of providers.

Hospitals, skilled nursing facilities, and home health agencies had come under increasing criticism on the grounds that they failed to follow sound business practices in their operations. Requiring annual projections of financing and objectives of operating budgets as a condition of provider participation is an assurance that these providers will—on their own—improve the soundness of their business practices.

This provision is effective for a provider of services for any fiscal year beginning after March 1973.

PROVIDERS AND SUPPLIERS

Effective: December 1972

UR COMMITTEE NOTIFICATIONS EXPANDED

UTILIZATION REVIEW COMMITTEE WILL NOTIFY ALL CONCERNED PARTIES OF ITS DECISION WHEN, IN REVIEWING A CURRENT SAMPLE OF ADMISSIONS, IT FINDS THAT A HOSPITAL OR SNF STAY IS NOT MEDICALLY NECESSARY

MEDICARE BENEFITS CEASE 3 DAYS AFTER NOTIFICATION

UR Committee Notifications Expanded

The utilization review committee in each hospital and skilled nursing facility has been required to review all long-stay cases and at least a sample of admissions. In reviewing a long-stay case, a utilization review committee which determines that further stay in the institution is not medically necessary is required to notify promptly the physician, the patient, and the institution of its finding. No Medicare payment is made for any services furnished after the third day following such notification. No similar notification was required under prior law in the review of admissions.

The 1972 amendments require a similar notification to all concerned parties, and a similar payment cut-off after 3 days, to be made where the utilization review committee in its sample or other review of admissions finds a case in which hospitalization or extended care is no longer necessary (or never was necessary). This removes the anomaly of continuing payment in such cases and makes parallel the treatment accorded long-stay cases and cases reviewed on a sample basis.

This provision is effective with respect to services furnished beginning with January 1973.

PROVIDERS AND SUPPLIERS

Effective: 10/30/72

VALIDATION OF JCAH SURVEYS

- STATE AGENCIES MAY SURVEY JCAH-ACCREDITED HOSPITALS
  - On a limited and selective sample basis
  - On a special basis when there is a substantial allegation of significant deficiency
- DHEW MAY ISSUE HIGHER OR MORE PRECISE STANDARDS THAN JCAH
- EACH YEAR THE SECRETARY WILL REPORT TO CONGRESS HIS EVALUATION OF JCAH ACCREDITATION

Validation of JCAH Surveys

Under the Medicare law, an institution is deemed to meet the certification requirements of Medicare (except for utilization review requirements) if the institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals (JCAH). About 4,500 of over 6,700 hospitals approved to participate in Medicare have been certified on the basis of JCAH accreditation.

The Congress found several areas of concern with respect to the JCAH role in the Medicare certification process. The JCAH survey process is not subject to Federal review and all JCAH survey reports are available only to the JCAH and the concerned facility. Thus, the Government is unable to determine the extent to which deficiencies may exist in about two-thirds of all participating hospitals, including almost all large hospitals. A further potential difficulty arises because Medicare cannot set standards that are higher than comparable JCAH requirements. This restriction has been interpreted to include establishment of any standards in any area where no JCAH requirement exists. Thus, the law serves to provide an almost blanket delegation of authority over hospital standards to a private agency. The 1972 amendments provide a mechanism for reasonable continuing validation—but not duplication—of the JCAH survey process.

The Secretary of Health, Education, and Welfare is authorized to arrange for State certifying agencies to survey JCAH-accredited hospitals on a selective and limited sample basis and on a special basis when DHEW receives a substantial allegation (with evidence) of a condition significantly adverse to patient health and safety. If in the course of a sample or special survey an institution is found to have significant deficiencies, the detailed Medicare standards and compliance procedures will be applied in place of the JCAH standards (following consultation with JCAH).

The Secretary is also authorized, after appropriate consultation with JCAH, to promulgate standards, as necessary for health and safety, which may be higher or more precise than those of the JCAH and which all hospitals would have to meet after appropriate and adequate time for compliance. Additionally, if the JCAH, as a condition for accreditation of a hospital, requires a utilization plan or imposes a standard that is equivalent to a standard promulgated by the Secretary, all hospitals so accredited by the JCAH will also comply with Medicare standards.

The Secretary's Annual Report to the Congress on Medicare will include an evaluation of the JCAH accreditation process as indicated by the survey process.

This provision was effective October 30, 1972.

PROVIDERS AND SUPPLIERS

Effective: Until 1978

PROFICIENCY TESTING EXPANDED

- PROFICIENCY TESTING PROGRAM WILL DETERMINE QUALIFICATIONS OF CERTAIN HEALTH CARE PERSONNEL
- OCCUPATIONS AFFECTED ARE:
  - Practical nurses
  - Therapists
  - Laboratory technicians and technologists
  - Cytotechnologists
  - X-ray technicians
  - Psychiatric technicians
  - Other health care technicians and technologists

Proficiency Testing Expanded

Hospitals, skilled nursing facilities, and home health agencies must be staffed with competent and qualified health care personnel in order to participate in the Medicare program. Federal regulations contain the criteria for judging the professional competency and qualifications of these health care workers. The regulations reflect a heavy reliance on licensure, formal education, formal training courses, and membership in or registration or certification by certain specialties of professional organizations. These methods are the principally accepted means of establishing professional qualifications in the health care field.

The amendments add an additional major way for health care personnel to be considered qualified for Medicare purposes. A testing program will be developed and conducted in cooperation with State health and licensure agencies and professional organizations to determine the proficiency of people not yet at a professional level. The tests will be designed to assess the technical knowledge and skills that are required for a specific job. (Such knowledge and skills may have been acquired through formal or informal means.) The occupations included in the proficiency testing program are practical nurses who are licensed by "waiver," therapists in specialties whose services are covered by the Federal health programs, laboratory technicians and technologists, cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. If an individual demonstrates proficiency as a result of such a test, both the Medicare and Medicaid programs will consider him to be qualified to perform the duties and functions of that occupation.

This additional major way of judging the qualifications and competency of health care personnel already has been started with respect to clinical laboratory personnel. That effort may prove effective but is still in the experimental stages. The expansion of the proficiency testing program to include other types of health care occupations may mean a significant increase in qualified personnel in these occupations—an increase that is particularly important in light of the serious shortage of qualified people.

The proficiency testing program will be applied until 1978. After December 31, 1977, people entering such health care fields will be required to meet the regular formal education, professional membership, or other requirements.

DISCLOSURE OF INFORMATION

Effective : Reports completed after 1/73

PERFORMANCE OF CONTRACTORS AND PROVIDERS

- **TYPES OF REPORTS TO BE MADE PUBLIC**
  - Individual contractor performance reviews
  - Comparative evaluations of contractors' performance
  - Program validation survey reports
- **AFFECTED CONTRACTORS AND PROVIDERS WILL BE GIVEN CHANCE TO REVIEW AND COMMENT**

Performance of Contractors and Providers

The amendments require prompt and timely public disclosure of evaluations and reports prepared after January 1973 and dealing with the operation of the Medicare and Medicaid programs, such as: (1) individual contractor performance reviews and other formal evaluations of the performance of carriers, intermediaries, and State agencies, including the reports of followup reviews; (2) comparative evaluations of contractor performance; and (3) program validation survey reports—with the names of individuals deleted.

Under prior law, such evaluations and program validation review reports regularly made by SSA to assist in program administration were not available to the public.

The new law provides that before public disclosure of evaluations and reports, the contractor, State agency, or facility concerned will be allowed up to 60 days to make comments on the accuracy of the findings and conclusions and that such comments would be incorporated into the report if portions objected to are not modified in line with the comment. Reports would not be required on deficiencies fully corrected within 60 days of the date contractors or providers of services were initially informed of them.

This change affords the public the opportunity to become aware of the performance of contractors and providers, with the accompanying opportunity to pressure for improvements in that performance. At the same time, however, the change safeguards contractors and providers from erroneous findings and conclusions being made public by affording them an opportunity to review and comment on the reports before they can be released.

CHART 52

DISCLOSURE OF INFORMATION

Effective: No later than 5/1/73

SURVEY REPORTS OF PROVIDERS

- REPORTS OF PRESENCE OR ABSENCE OF INSTITUTION'S SIGNIFICANT DEFICIENCIES TO BE MADE AVAILABLE IN SOCIAL SECURITY OFFICES
- REPORTS AVAILABLE WITHIN 90 DAYS OF COMPLETION OF A SURVEY
- APPLIES TO STATUTORY AND REGULATORY REQUIREMENTS FOR PARTICIPATING PROVIDERS

Survey Reports of Providers

Physicians and the public, in general, are unaware currently as to which hospitals, skilled nursing facilities, home health agencies, and other providers have had significant deficiencies recorded in Medicare survey reports and which have not. This absence of public knowledge impairs informed choice among health care facilities and limits public efforts toward improvement of deficient facilities. The Congress concluded that ready public access to this information would help substantially in meeting these problems.

Accordingly, the amendments require the Secretary of Health, Education, and Welfare to make reports of an institution's significant deficiencies or the absence thereof (in areas such as staffing, fire and other safety requirements, and sanitation) a matter of public record readily and generally available. Within 90 days following the completion of a survey of a health care facility or organization, those portions of the survey findings relating to statutory requirements and major additional health and safety requirements will be available for inspection in social security offices. (This provision applies also to Medicaid; the reports with respect to those providers will be available in both social security and local welfare offices.)

This provision applies to surveys completed after April 1973. Thus, considering the 90-day period already identified, a report completed on May 1, 1973 would be made available to the public on or before July 29, 1973.

CHART 53

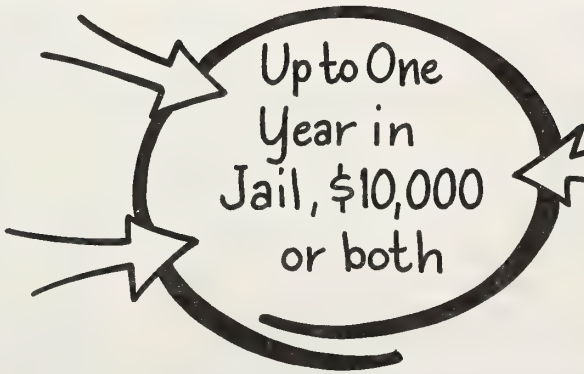
DISCLOSURE OF INFORMATION

Effective 10/30/72

PENALTIES FOR FRAUD AND FALSE REPORTING

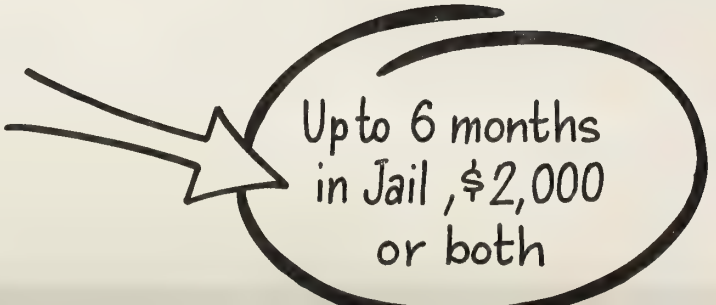
KICKBACKS, BRIBES, REBATES
(Soliciting, Offering, or Accepting)

CONCEALMENT OR FAILURE TO DISCLOSE FACTS OR EVENTS AFFECTING RIGHT TO BENEFITS



CONVERTING BENEFITS OR PAYMENTS TO IMPROPER USE

MAKING FALSE STATEMENT TO GAIN CERTIFICATION OR RECERTIFICATION AS PARTICIPATING PROVIDER



Penalties for Fraud and False Reporting

A false statement in an application for payment under social security (including Medicare), with intent to defraud is defined as a misdemeanor and carries a penalty of up to 1 year of imprisonment, a fine of $10,000, or both. However, the penalty provisions applicable to Medicare did not specifically include as fraud such practices as kickbacks and bribes. There was no criminal penalty provision applicable to Medicaid. Additionally, there were no penalties for false reporting with respect to health and safety conditions in participating institutions.

This amendment broadens the penalty provisions to include the soliciting, offering, or acceptance of kickbacks or bribes by providers of health care services; concealment or failure to disclose an event affecting a person's right to benefits with intent to defraud; or converting benefit payments to improper use. The penalty for such acts is imprisonment up to one year, a fine of $10,000, or both.

Similarly, anyone who knowingly and willfully makes a false statement of material fact with respect to the conditions and operation of a facility or agency to secure Medicare or Medicaid certification or re-certification would be guilty of a misdemeanor punishable by up to 6 months imprisonment, a fine of not more than $2,000, or both.

Because of the special problems associated with the Medicare program, a specific provision defining the acts subject to penalty is necessary.

The practices so defined have long been regarded as unethical by professional organizations, are unlawful in some jurisdictions, and contribute appreciably to the cost of the program.

CHART 54

STUDIES

Effective : 10/30/72

EXPERIMENTS AND DEMONSTRATION PROJECTS

PROSPECTIVE REIMBURSEMENT

EXTENDED CARE

INTERMEDIATE CARE AND HOMEMAKER SERVICES

AMBULATORY SURGICAL CENTERS

PHYSICIAN ASSISTANTS

OTHER EXPERIMENTAL STUDIES

Experiments and Demonstration Projects

The amendments authorize experiments and demonstration projects in a variety of areas. The experiments and demonstration projects developed and carried out are to be of sufficient scope and on a wide enough scale to permit thorough evaluation and to give reasonable assurance that, if adopted, similar results will be obtained generally in the operation of the program.

All of the experiments and demonstration projects are to be departures from the provisions of the Medicare law.

For example, institutional providers are paid on the basis of the reasonable cost of the covered services they furnish. An interim payment rate is established for the accounting period and that rate is followed during the period. When the accounting period ends and final costs are determined, a retroactive corrective adjustment is made. Experience with this method of reimbursement has demonstrated, however, that it gives little incentive to providers to contain costs or to produce the services in the most efficient and effective manner. The amendments provide for major experimentation with prospective reimbursement, where a final payment rate is set before the institution's accounting period begins, with no provision for retroactive adjustment of the total amount payable by the program. Prospective reimbursement offers the promise of encouraging institutional managers, through financial incentives, to plan, innovate, and generally to manage effectively.

Other studies and experiments will be conducted to determine the effects of reducing or eliminating the 3-day prior hospitalization requirement for extended care benefits.

Also authorized are experiments and demonstration projects to determine whether coverage of intermediate care facilities and homemaker services would provide suitable alternatives to present post-hospital benefits.

Other experiments and demonstration projects are authorized to evaluate the use of ambulatory surgical centers and other incidental services; the most appropriate and equitable method of paying for services of physicians' assistants; reimbursement for day care services; the use of more clinical psychologists' services; performance incentive contracts for carriers and intermediaries; expanded use of negotiated reimbursement; adoption of State-established payment rates; and combined payment for services of interns, residents, and supervisory physicians.

STUDIES

Effective: 10/30/72

DURABLE MEDICAL EQUIPMENT

- REIMBURSEMENT EXPERIMENTS WILL BE CONDUCTED TO PREVENT UNNECESSARY SMI EXPENSE FROM PROLONGED RENTALS

- ANY APPROACH FOUND WORKABLE, DESIRABLE, AND ECONOMICAL CAN BE IMPLEMENTED NATIONWIDE WITHOUT FURTHER LEGISLATION

Durable Medical Equipment

Presently, beneficiaries whose medical conditions require durable medical equipment (such as hospital beds, wheelchairs, and pressure breathing machines) for home use may receive reimbursement under the supplementary medical insurance program. Beneficiaries have the option to rent or purchase the equipment. In the case of purchase, SMI reimbursement is made in monthly installments for relatively expensive equipment (that for which the reasonable charge is over $50) and in a lump-sum for less expensive equipment, if that method of payment is more practical or less expensive. When a beneficiary elects to rent durable medical equipment and the rental payments from SMI continue until they have exceeded the purchase price, the program has incurred, in those cases where the situation was readily predictable, an unreasonable expense.

The amendments authorize reimbursement experiments (in various geographical areas) designed to prevent unreasonable expenses to SMI resulting from such prolonged rentals. Any approach found to be workable, desirable, and economical can be implemented nationwide without further legislation. The Congress gave three examples of *possible* approaches.

1. The supplier could contract with the Government under arrangements whereby rental would be by means of a lease-purchase arrangement which would provide for rental payments to terminate when the purchase price was reached.

2. Lump-sum purchase payment could be made where it was determined that purchase would be more economical than lease-purchase.

3. The 20 percent coinsurance could be waived where the purchase price for used equipment was at least 25 percent less than the price for new equipment, to encourage beneficiaries to purchase used equipment.

PROGRAM COORDINATION FOR FEDERAL EMPLOYEES

Effective: January 1, 1975

MEDICARE AND FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

- NO MEDICARE BENEFIT WILL BE PAID FOR THE SERVICES THAT ARE ALSO COVERED UNDER FEHB

UNLESS

- FEHB IS MODIFIED TO OFFER COVERAGE THAT SUPPLEMENTS MEDICARE COVERAGE

AND

- CONTRIBUTIONS TOWARD PREMIUMS FOR FEHB COVERAGE ARE MAINTAINED BY THE GOVERNMENT OR THE FEHB PLAN

Medicare and Federal Employees Health Benefits Program

When Medicare was enacted in 1965, it was intended that it would provide the basic health insurance protection for people age 65 and over and that it would pay its benefits in full without regard to any other benefit that might be payable under an employee health benefits plan. At the same time, it was expected that such plans would adjust their benefit policies to complement the Medicare protection rather than duplicate the benefits.

Unlike most employers, the Federal Government has not modified the health insurance protection it makes available to Federal employees 65 or over or to Federal annuitants entitled to Medicare so that their protection under the Federal Employees Health Benefits program (FEHB) would be supplementary to Medicare. The FEHB plans cover many of the same health care expenses that are covered under Medicare. In addition, FEHB plans contain a "non-duplication" clause which, in essence, excludes the amount of Medicare benefits from the total FEHB benefits payable. As a result, Federal annuitants and employees entitled to both programs do not receive the full value of the protection offered under Medicare and FEHB.

Therefore, the amendments provide that effective January 1, 1975, no payment will be made under Medicare for the same services covered under a FEHB plan unless in the meantime the FEHB plan or program is modified to make available coverage supplementary to Medicare benefits. The Federal contribution (or, in a limited number of cases, the contribution from the individual FEHB plan) toward the health insurance premiums of FEHB beneficiaries also must be continued.

This provision is designed to give the Federal Government a strong incentive to modify the FEHB program so that benefits under FEHB plans will supplement, rather than duplicate, Medicare benefits.